Australian Government
Department of Health

PBS

Schedule of Pharmaceutical Benefits

Effective 1 February 2018

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

© Commonwealth of Australia
ISSN 1037-3667

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

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

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

Contents

Fees, Patient Contributions and Safety Net Thresholds **1**
Summary of Changes **2**
About the Schedule **10**
Symbols and Abbreviations Used in the Schedule 10
Restricted Benefits 11
Guidelines and General Statements **12**
General Statement for Lipid-Lowering Drugs 12
General Statement for Drugs for the Treatment of Hepatitis C 14
Pharmaceutical Benefits Schedules **16**
Prescriber Bag 17
General Pharmaceutical Benefits 23
Palliative Care 748
Highly Specialised Drugs Program (Private Hospital) 761
Highly Specialised Drugs Program (Public Hospital) 996
Highly Specialised Drugs Program (Community Access) 1232
Botulinum Toxin Program 1253
Growth Hormone Program 1261
IVF Treatment Program 1536
Opiate Dependence Treatment Program 1542
Repatriation Pharmaceutical Benefits Scheme 1545
Extemporaneously Prepared Benefits **1599**
Drug Tariff 1600
Container Prices 1603
Standard Formula Preparations 1604
Codes, Maximum Quantities, and Number of Repeats for Extemporaneously Prepared Benefits 1605
Index of Manufacturers' Code **1606**
Generic/Proprietary Index **1609**

Fees, Patient Contributions and Safety Net Thresholds

The following fees, patient contributions and safety net thresholds apply as at 1 February 2018 and are included, where applicable, in prices published in the Schedule —

Dispensing Fees:	Ready-prepared	$7.15
	Dangerous drug fee	$3.01
	Extemporaneously-prepared	$9.19
	Allowable additional patient charge*	$4.45
Additional Fees (for safety net prices):	Ready-prepared	$1.21
	Extemporaneously-prepared	$1.57
Patient Co-payments:	General	$39.50
	Concessional	$6.40
Safety Net Thresholds:	General	$1521.80
	Concessional	$384.00
Safety Net Card Issue Fee:		$9.91

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

Summary of Changes

These changes to the Schedule of Pharmaceutical Benefits are effective from 1 February 2018. The Schedule is updated on the first day of each month and is available on the internet at www.pbs.gov.au.

Prescriber Bag

Additions

Addition – Item

11233F **NALOXONE**, naloxone hydrochloride 400 microgram/mL injection, 10 x 1 mL ampoules *(NARCAN)*

Deletions

Deletion – Item

3457Y **BENZATROPINE**, benzatropine mesilate 2 mg/2 mL injection, 5 x 2 mL ampoules *(Cogentin)*

Alterations

Alteration – Manufacturer Code

		From	*To*
3496B	*Salbutamol AN* – **SALBUTAMOL**, salbutamol 2.5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules	JU	ED
3497C	*Salbutamol AN* – **SALBUTAMOL**, salbutamol 5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules	JU	ED

General Pharmaceutical Benefits

Additions

Addition – Item

11227X **CEFUROXIME**, cefuroxime 250 mg tablet, 20 *(Zinnat)*

11228Y **CEFUROXIME**, cefuroxime 250 mg tablet, 20 *(Zinnat)*

11245W **GLYCOMACROPEPTIDE FORMULA WITH LONG CHAIN POLYUNSATURATED FATTY ACID AND DOCOSAHEXAENOIC ACID AND LOW PHENYLALANINE**, glycomacropeptide formula with long chain polyunsaturated fatty acid and docosahexaenoic acid and low phenylalanine powder for oral liquid, 30 x 27 g sachets *(PKU Sphere15)*

Addition – Brand

5541P *APO-Dorzolamide, TX* – **DORZOLAMIDE**, dorzolamide 2% eye drops, 5 mL

8488R *APO-Dorzolamide, TX* – **DORZOLAMIDE**, dorzolamide 2% eye drops, 5 mL

5542Q *APO-Dorzolamide/Timolol 20/5, TX* – **DORZOLAMIDE + TIMOLOL**, dorzolamide 2% + timolol 0.5% eye drops, 5 mL

8567X *APO-Dorzolamide/Timolol 20/5, TX* – **DORZOLAMIDE + TIMOLOL**, dorzolamide 2% + timolol 0.5% eye drops, 5 mL

9202H *QUEPINE XR, RF* – **QUETIAPINE**, quetiapine 50 mg modified release tablet, 60

9203J *QUEPINE XR, RF* – **QUETIAPINE**, quetiapine 200 mg modified release tablet, 60

9204K *QUEPINE XR, RF* – **QUETIAPINE**, quetiapine 300 mg modified release tablet, 60

9205L *QUEPINE XR, RF* – **QUETIAPINE**, quetiapine 400 mg modified release tablet, 60

Deletions

Deletion – Item

3038X **BENZATROPINE**, benzatropine mesilate 2 mg/2 mL injection, 5 x 2 mL ampoules *(Cogentin)*

5031T **BENZATROPINE**, benzatropine mesilate 2 mg/2 mL injection, 5 x 2 mL ampoules *(Cogentin)*

2878L **CROMOGLYCATE**, sodium cromoglycate 20 mg powder for inhalation, 100 capsules *(Intal Spincaps)*

1798P **CYPROHEPTADINE**, cyproheptadine hydrochloride 4 mg tablet, 100 *(Periactin)*

1821W **METRONIDAZOLE**, metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags *(Metronidazole Sandoz IV)*

1832K **METRONIDAZOLE**, metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags *(Metronidazole Sandoz IV)*

8282X **MILK POWDER LACTOSE FREE FORMULA**, milk powder lactose free formula powder for oral liquid, 900 g *(S-26 LF)*

8864M **PREPARED COAL TAR**, prepared coal tar 1% w/w lotion, 100 mL *(Exorex)*

2114G **TESTOSTERONE ENANTATE**, testosterone enantate 250 mg/mL injection, 3 x 1 mL syringes *(Primoteston Depot)*

10113G **TICARCILLIN + CLAVULANIC ACID**, ticarcillin 3 g + clavulanic acid 100 mg injection, 3.1 g vial *(Timentin)*

10125X **TICARCILLIN + CLAVULANIC ACID**, ticarcillin 3 g + clavulanic acid 100 mg injection, 3.1 g vial *(Timentin)*

Deletion – Brand

8188Y *GLYBOSAY, RW* – **ACARBOSE**, acarbose 50 mg tablet, 90

8189B *GLYBOSAY, RW* – **ACARBOSE**, acarbose 100 mg tablet, 90

8511Y *Alendronate AN, EA* – **ALENDRONATE**, alendronate 70 mg tablet, 4

5006L *AmoxyClav GH 875/125, GQ* – **AMOXICILLIN + CLAVULANIC ACID**, amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

8254K *AmoxyClav GH 875/125, GQ* – **AMOXICILLIN + CLAVULANIC ACID**, amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

8295N *Candesartan GH, GQ* – **CANDESARTAN**, candesartan cilexetil 4 mg tablet, 30

1169M *Ozcef, RA* – **CEFACLOR**, cefaclor 375 mg modified release tablet, 10

5045M *Ozcef, RA* – **CEFACLOR**, cefaclor 375 mg modified release tablet, 10

8019C *Procur 100, ED* – **CYPROTERONE**, cyproterone acetate 100 mg tablet, 50

2532G *Donepezil-GA, ED* – **DONEPEZIL**, donepezil hydrochloride 5 mg tablet, 28

8495D *Donepezil-GA, ED* – **DONEPEZIL**, donepezil hydrochloride 5 mg tablet, 28

2479L *Donepezil-GA, ED* – **DONEPEZIL**, donepezil hydrochloride 10 mg tablet, 28

8496E *Donepezil-GA, ED* – **DONEPEZIL**, donepezil hydrochloride 10 mg tablet, 28

9155W *Duloxetine GH, GQ* – **DULOXETINE**, duloxetine 30 mg enteric capsule, 28

9156X *Duloxetine GH, GQ* – **DULOXETINE**, duloxetine 60 mg enteric capsule, 28

2487X *Pepzan, ED* – **FAMOTIDINE**, famotidine 20 mg tablet, 60

2488Y *Pepzan, ED* – **FAMOTIDINE**, famotidine 40 mg tablet, 30

8404H *Irbesartan HCTZ AN 150/12.5, EA* – **IRBESARTAN + HYDROCHLOROTHIAZIDE**, irbesartan 150 mg + hydrochlorothiazide 12.5 mg tablet, 30

8405J *Irbesartan HCTZ AN 300/12.5, EA* – **IRBESARTAN + HYDROCHLOROTHIAZIDE**, irbesartan 300 mg + hydrochlorothiazide 12.5 mg tablet, 30

2136K *Irbesartan HCTZ AN 300/25, EA* – **IRBESARTAN + HYDROCHLOROTHIAZIDE**, irbesartan 300 mg + hydrochlorothiazide 25 mg tablet, 30

1394J *Microgynon 30 ED, BN* – **LEVONORGESTREL + ETHINYLESTRADIOL**, levonorgestrel 150 microgram + ethinylestradiol 30 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

2430X *Metformin-GA, ED* – **METFORMIN**, metformin hydrochloride 500 mg tablet, 100

1801T *Metformin-GA, ED* – **METFORMIN**, metformin hydrochloride 850 mg tablet, 60

8607B *Metformin-GA, ED* – **METFORMIN**, metformin hydrochloride 1 g tablet, 90

9151P *Pramipexole GH, GQ* – **PRAMIPEXOLE**, pramipexole dihydrochloride monohydrate 125 microgram tablet, 30

9152Q *Pramipexole GH, GQ* – **PRAMIPEXOLE**, pramipexole dihydrochloride monohydrate 250 microgram tablet, 100

9153R *Pramipexole GH, GQ* – **PRAMIPEXOLE**, pramipexole dihydrochloride monohydrate 1 mg tablet, 100

1316G *Ramipril Winthrop, WA* – **RAMIPRIL**, ramipril 10 mg tablet, 30

2011W *Simvastatin-GA 10, ED* – **SIMVASTATIN**, simvastatin 10 mg tablet, 30

9242K *Simvastatin-GA 10, ED* – **SIMVASTATIN**, simvastatin 10 mg tablet, 30

2012X *Simvastatin-GA 20, ED* – **SIMVASTATIN**, simvastatin 20 mg tablet, 30

9243L *Simvastatin-GA 20, ED* – **SIMVASTATIN**, simvastatin 20 mg tablet, 30

8173E *Simvastatin-GA 40, ED* – **SIMVASTATIN**, simvastatin 40 mg tablet, 30

9244M *Simvastatin-GA 40, ED* – **SIMVASTATIN**, simvastatin 40 mg tablet, 30

8313M *Simvastatin-GA 80, ED* – **SIMVASTATIN**, simvastatin 80 mg tablet, 30

9245N *Simvastatin-GA 80, ED* – **SIMVASTATIN**, simvastatin 80 mg tablet, 30

2285G *Sebifin 250, RA* – **TERBINAFINE**, terbinafine 250 mg tablet, 42

2804N *Sebifin 250, RA* – **TERBINAFINE**, terbinafine 250 mg tablet, 42

8523N *GA Tramadol SR 100mg, ED* – **TRAMADOL**, tramadol hydrochloride 100 mg modified release tablet, 20

8525Q *GA Tramadol SR 200mg, ED* – **TRAMADOL**, tramadol hydrochloride 200 mg modified release tablet, 20

2269K *Vycin IV, EA* – **VANCOMYCIN**, vancomycin 1 g injection, 1 vial

2270L *Vycin IV, EA* – **VANCOMYCIN**, vancomycin 1 g injection, 1 vial

5083M *Vycin IV, EA* – **VANCOMYCIN**, vancomycin 1 g injection, 1 vial

Deletion – Note

10703H **RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*

10719E **RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*

Deletion – Restriction

10958R **EVOLOCUMAB**, evolocumab 140 mg/mL injection, 1 mL injection device *(Repatha)*

Alterations

Alteration – Item Description

From
1976B **ICATIBANT**, ICATIBANT Injection 30 mg (as acetate) in 3 mL single use pre-filled syringe, 1 *(Firazyr)*
To
1976B **ICATIBANT**, icatibant 30 mg/3 mL injection, 3 mL syringe *(Firazyr)*

From
2096H **SULFASALAZINE**, SULFASALAZINE Tablet 500 mg (enteric coated), 100 *(Pyralin EN, Salazopyrin-EN)*
To
2096H **SULFASALAZINE**, sulfasalazine 500 mg enteric tablet, 100 *(Pyralin EN, Salazopyrin-EN)*

From
9209Q **SULFASALAZINE**, SULFASALAZINE Tablet 500 mg (enteric coated), 100 *(Pyralin EN, Salazopyrin-EN)*
To
9209Q **SULFASALAZINE**, sulfasalazine 500 mg enteric tablet, 100 *(Pyralin EN, Salazopyrin-EN)*

From
9411H **TERIPARATIDE**, teriparatide 20 microgram injection, 2.4 mL cartridge *(Forteo)*
To
9411H **TERIPARATIDE**, teriparatide 20 microgram/dose injection, 28 doses *(Forteo)*

Alteration – Brand Name

From
11071Q *PKU Sphere, VF* – **GLYCOMACROPEPTIDE FORMULA WITH LONG CHAIN POLYUNSATURATED FATTY ACID AND DOCOSAHEXAENOIC ACID AND LOW PHENYLALANINE**, glycomacropeptide formula with long chain polyunsaturated fatty acid and docosahexaenoic acid and low phenylalanine powder for oral liquid, 30 x 35 g sachets
To
11071Q *PKU Sphere20, VF* – **GLYCOMACROPEPTIDE FORMULA WITH LONG CHAIN POLYUNSATURATED FATTY ACID AND DOCOSAHEXAENOIC ACID AND LOW PHENYLALANINE**, glycomacropeptide formula with long chain polyunsaturated fatty acid and docosahexaenoic acid and low phenylalanine powder for oral liquid, 30 x 35 g sachets

Alteration – Restriction

11170X **IDELALISIB**, idelalisib 100 mg tablet, 60 *(Zydelig)*

11162L **IDELALISIB**, idelalisib 150 mg tablet, 60 *(Zydelig)*

10703H **RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*

10719E **RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*

Alteration – Manufacturer Code

		From	*To*
2000G	*Salbutamol AN* – **SALBUTAMOL**, salbutamol 2.5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules	JU	ED
2001H	*Salbutamol AN* – **SALBUTAMOL**, salbutamol 5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules	JU	ED

Alteration – Number of Repeats

		From	*To*
10703H	**RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*	2	6
10719E	**RITUXIMAB**, rituximab 1.4 g/11.7 mL injection, 11.7 mL vial *(Mabthera SC)*	6	5

Advance Notices

1 March 2018

Deletion – Brand

5052X *Zinnat, AS* – **CEFUROXIME**, cefuroxime 250 mg tablet, 14

8292K *Zinnat, AS* – **CEFUROXIME**, cefuroxime 250 mg tablet, 14

8973G *Actonel EC Combi, UA* – **RISEDRONATE (&) CALCIUM CARBONATE**, RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

10551H *Terry White Chemists Rizatriptan, TW* – **RIZATRIPTAN**, rizatriptan 10 mg orally disintegrating tablet, 2

10551H *Chem mart Rizatriptan, CH* – **RIZATRIPTAN**, rizatriptan 10 mg orally disintegrating tablet, 2

2574L *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 20 mg tablet, 30

2584B *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 10 mg tablet, 30

2590H *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 5 mg tablet, 30

2594M *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 40 mg tablet, 30

2606E *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 5 mg tablet, 30

2609H *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 20 mg tablet, 30

2628H *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 10 mg tablet, 30

2636R *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 40 mg tablet, 30

3402C *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 5 mg tablet, 30

3403D *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 10 mg tablet, 30

3404E *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 20 mg tablet, 30

3405F *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 40 mg tablet, 30

9042X *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 5 mg tablet, 30

9043Y *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 10 mg tablet, 30

9044B *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 20 mg tablet, 30

9045C *Rosuvastatin GH, GQ* – **ROSUVASTATIN**, rosuvastatin 40 mg tablet, 30

1 May 2018

Deletion – Brand

8974H *Actonel EC Combi D, UA* – **RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL**, RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

Highly Specialised Drugs Program (Private Hospital)

Additions

Addition – Item

11237K **OCRELIZUMAB**, ocrelizumab 300 mg/10 mL injection, 10 mL vial *(Ocrevus)*

Alterations

Alteration – Restriction

11036W **LENALIDOMIDE**, lenalidomide 5 mg capsule, 21 *(Revlimid)*

9642L **LENALIDOMIDE**, lenalidomide 5 mg capsule, 21 *(Revlimid)*

11063G **LENALIDOMIDE**, lenalidomide 10 mg capsule, 21 *(Revlimid)*

9643M **LENALIDOMIDE**, lenalidomide 10 mg capsule, 21 *(Revlimid)*

11042E **LENALIDOMIDE**, lenalidomide 15 mg capsule, 21 *(Revlimid)*

9644N **LENALIDOMIDE**, lenalidomide 15 mg capsule, 21 *(Revlimid)*

11055W **LENALIDOMIDE**, lenalidomide 25 mg capsule, 21 *(Revlimid)*

9645P **LENALIDOMIDE**, lenalidomide 25 mg capsule, 21 *(Revlimid)*

10417G **POMALIDOMIDE**, pomalidomide 3 mg capsule, 21 *(Pomalyst)*

10386P **POMALIDOMIDE**, pomalidomide 4 mg capsule, 21 *(Pomalyst)*

Alteration – Manufacturer Code

		From	*To*
6101D	*Clozaril 25* – **CLOZAPINE**, clozapine 25 mg tablet, 100	NV	GO
6102E	*Clozaril 100* – **CLOZAPINE**, clozapine 100 mg tablet, 100	NV	GO

Highly Specialised Drugs Program (Public Hospital)

Additions

Addition – Item

11242Q **OCRELIZUMAB**, ocrelizumab 300 mg/10 mL injection, 10 mL vial *(Ocrevus)*

Alterations

Alteration – Restriction

11029L **LENALIDOMIDE**, lenalidomide 5 mg capsule, 21 *(Revlimid)*

5783J **LENALIDOMIDE**, lenalidomide 5 mg capsule, 21 *(Revlimid)*

11064H **LENALIDOMIDE**, lenalidomide 10 mg capsule, 21 *(Revlimid)*

5784K **LENALIDOMIDE**, lenalidomide 10 mg capsule, 21 *(Revlimid)*

11062F **LENALIDOMIDE**, lenalidomide 15 mg capsule, 21 *(Revlimid)*

5785L **LENALIDOMIDE**, lenalidomide 15 mg capsule, 21 *(Revlimid)*

11041D **LENALIDOMIDE**, lenalidomide 25 mg capsule, 21 *(Revlimid)*

5786M **LENALIDOMIDE**, lenalidomide 25 mg capsule, 21 *(Revlimid)*

10406Q **POMALIDOMIDE**, pomalidomide 3 mg capsule, 21 *(Pomalyst)*

10387Q **POMALIDOMIDE**, pomalidomide 4 mg capsule, 21 *(Pomalyst)*

Alteration – Manufacturer Code

		From	*To*
5628F	*Clozaril 25* – **CLOZAPINE**, clozapine 25 mg tablet, 100	NV	GO
5629G	*Clozaril 100* – **CLOZAPINE**, clozapine 100 mg tablet, 100	NV	GO

Highly Specialised Drugs Program (Community Access)

Additions

Addition – Item

11246X **ABACAVIR + LAMIVUDINE**, abacavir 600 mg + lamivudine 300 mg tablet, 30 *(Abacavir/Lamivudine GH 600/300)*

11248B **RALTEGRAVIR**, raltegravir 600 mg tablet, 60 *(Isentress HD)*

Addition – Equivalence Indicator

10357D *Kivexa, VI* – **ABACAVIR + LAMIVUDINE**, abacavir 600 mg + lamivudine 300 mg tablet, 30

Addition – Note

10357D **ABACAVIR + LAMIVUDINE**, abacavir 600 mg + lamivudine 300 mg tablet, 30 *(Kivexa)*

Alterations

Alteration – Manufacturer Code

		From	*To*
10289M	*Clozaril 25* – **CLOZAPINE**, clozapine 25 mg tablet, 100	NV	GO
10358E	*Clozaril 100* – **CLOZAPINE**, clozapine 100 mg tablet, 100	NV	GO

Growth Hormone Program

Advance Notices

1 April 2018

Deletion – Brand

10441M *Omnitrope, SZ* – **SOMATROPIN**, somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10481P *Omnitrope, SZ* – **SOMATROPIN**, somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

6311E *Omnitrope, SZ* – **SOMATROPIN**, somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

Repatriation Pharmaceutical Benefits

Deletions

Deletion – Item

10186D **PARACETAMOL + CODEINE**, paracetamol 500 mg + codeine phosphate hemihydrate 15 mg tablet, 20 *(Pharmacy Action Paracetamol Plus Codeine)*

Alterations

Alteration – Item Description

From
4408B **PINE TAR WITH TRIETHANOLAMINE LAURYL SULFATE**, PINE TAR with TRIETHANOLAMINE LAURYL SULFATE Solution 23 mg-60 mg per mL (2.3%-6%), 500 mL, 1 *(Pinetarsol)*

To
4408B **TAR + TRIETHANOLAMINE LAURYL SULFATE**, tar 2.3% + triethanolamine lauryl sulfate 6% solution, 500 mL *(Pinetarsol)*

Alteration – Brand Name

From
4896Q *DuoDERM Paste H7930, CC* – **DRESSING HYDROCOLLOID CAVITY WOUND**, dressing hydrocolloid cavity wound paste, 30 g

To
4896Q *DuoDERM Paste 187930, CC* – **DRESSING HYDROCOLLOID CAVITY WOUND**, dressing hydrocolloid cavity wound paste, 30 g

From
4907G *DuoDERM Extra Thin H7955, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE**, dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

To
4907G *DuoDERM Extra Thin 187955, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE**, dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

From
4897R *DuoDERM CGF H7660, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**, dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5

To
4897R *DuoDERM CGF 187660, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**, dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5

From
4920Y *DuoDERM CGF H7662, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**, dressing hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5

To
4920Y *DuoDERM CGF 187662, CC* – **DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**, dressing hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5

From

4912M *DuoDERM Gel H7990, CC* – **DRESSING HYDROGEL AMORPHOUS**, dressing hydrogel amorphous gel, 10 x 15 g

To

4912M *DuoDERM Gel 187990, CC* – **DRESSING HYDROGEL AMORPHOUS**, dressing hydrogel amorphous gel, 10 x 15 g

Advance Notices

1 March 2018

Deletion – Brand

2220W *Actonel EC Combi, UA* – **RISEDRONATE (&) CALCIUM CARBONATE**, RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

1 May 2018

Deletion – Brand

2254P *Actonel EC Combi D, UA* – **RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL**, RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

About the Schedule

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

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

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

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

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

Symbols and Abbreviations Used in the Schedule

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

Restricted Benefits

All restricted items have separate headings for authority and non-authority items. In each case these items may be prescribed as pharmaceutical benefits only for use for one of the specified indications. Where more than one indication is specified for an Authority required or Restricted pharmaceutical benefit, each indication is separated from the preceding indication by a semi-colon and commences on the next line. In the case of Authority required (STREAMLINED) items, each indication will also include a four digit streamlined authority code. The drug may be prescribed as a pharmaceutical benefit for a patient who qualifies under any of the specified indications.

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

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

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

Guidelines and General Statements

General Statement for Lipid-Lowering Drugs

Use the following criteria to determine patient eligibility for subsidisation under the PBS for lipid modifying agents.

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

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

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

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

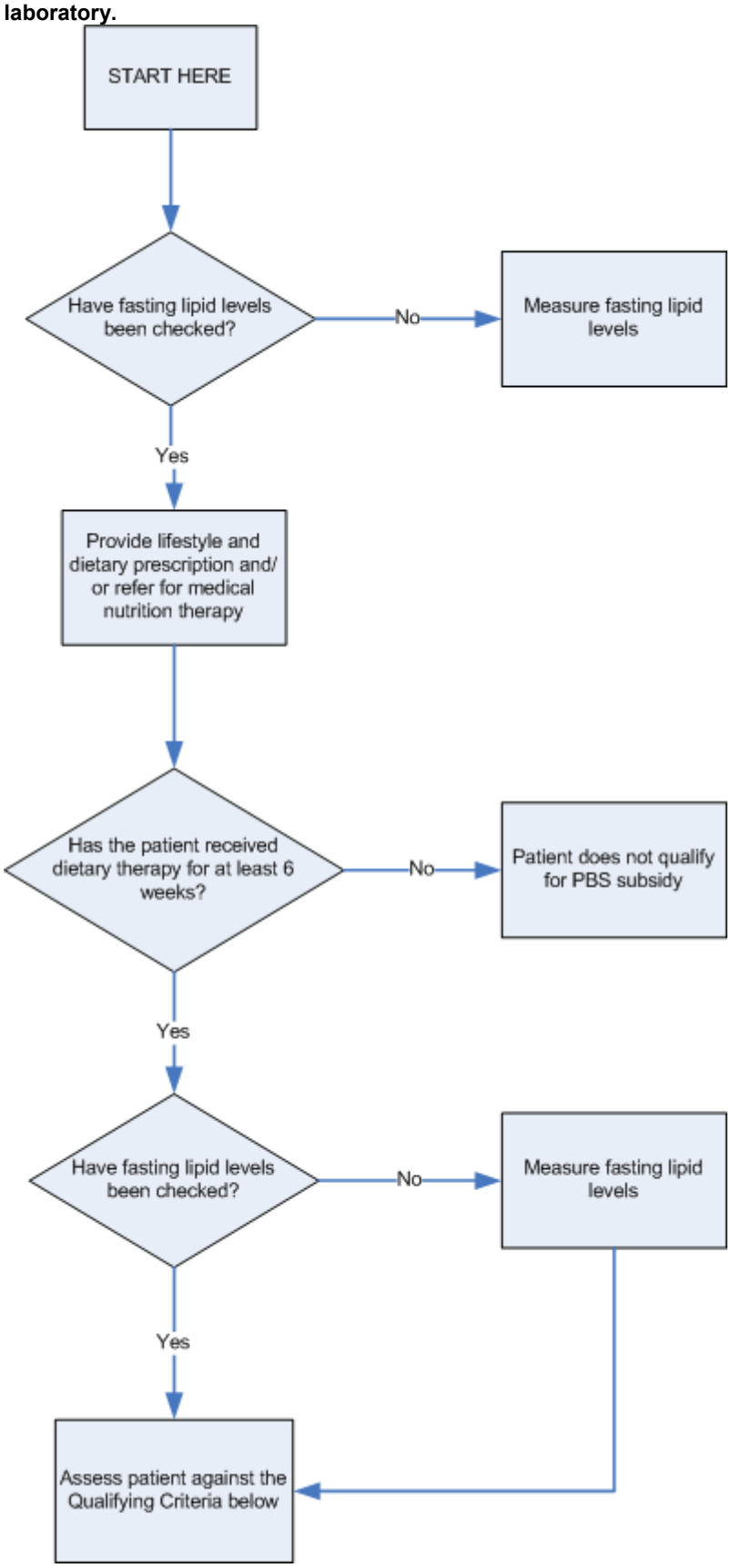
- coronary heart disease which has become symptomatic
- cerebrovascular disease which has become symptomatic
- peripheral vascular disease which has become symptomatic
- diabetes mellitus with microalbuminuria (defined as urinary albumin excretion rate of >20mcg/min or urinary albumin to creatinine ratio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

POST-DIETARY QUALIFYING CRITERIA

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

PATIENT CATEGORY	LIPID LEVELS FOR PBS SUBSIDY
Patients with diabetes mellitus not otherwise included	total cholesterol > 5.5 mmol/L
Aboriginal or Torres Strait Islander patients Patients with hypertension	total cholesterol > 6.5 mmol/L **or** total cholesterol > 5.5 mmol/L **and** HDL cholesterol < 1 mmol/L
Patients with HDL cholesterol < 1 mmol/L	total cholesterol > 6.5 mmol/L
Patients with familial hypercholesterolaemia identified by: • DNA mutation; or • tendon xanthomas in the patient or their first or second degree relative Patients with: • family history of coronary heart disease which has become symptomatic before the age of 60 years in one or more first degree relatives; or • family history of coronary heart disease which has become symptomatic before the age of 50 years in one or more second degree relatives	If aged 18 years or less at treatment initiation: LDL cholesterol > 4 mmol/L If aged more than 18 years at treatment initiation: LDL cholesterol > 5 mmol/L **or** total cholesterol > 6.5 mmol/L **or** total cholesterol > 5.5 mmol/L **and** HDL cholesterol < 1 mmol/L
Patients not eligible under the above: • men aged 35 to 75 years • post-menopausal women aged up to 75 years	total cholesterol > 7.5 mmol/L **or** triglyceride > 4 mmol/L
Patients not otherwise included	total cholesterol > 9 mmol/L **or** triglyceride > 8 mmol/L

If your patient is not identified as being in any of the above very high risk categories, then use the flow-chart and table below to determine whether your patient satisfies the following criteria for subsidisation under the PBS. Document how the patient meets each of these steps in the patient record. Lipid levels must be measured at an accredited laboratory.



General Statement for Drugs for the Treatment of Hepatitis C

Use the following criteria to determine patient eligibility for subsidisation under the PBS for hepatitis C treating agents.

By writing a PBS prescription, the prescriber is certifying the patient satisfies the qualifying criteria set out below and the use in accordance with the registered indications which differ between agents in this class – refer to the current Product Information for details.

Population criteria:
Patient must be aged 18 years or older.

Treatment criteria:
Must be treated by a medical practitioner or an authorised nurse practitioner[1] experienced in the treatment of chronic hepatitis C infection; or in consultation with a gastroenterologist, hepatologist or infectious diseases physician experienced in the treatment of chronic hepatitis C infection.

The following information must be provided at the time of application:

a. the hepatitis C virus genotype; and
b. the patient's cirrhotic status (non-cirrhotic or cirrhotic)

The following information must be documented in the patient's medical records:

a. evidence of chronic hepatitis C infection (repeatedly antibody to hepatitis C virus (anti-HCV) positive and hepatitis C virus ribonucleic acid (HCV RNA) positive); and
b. evidence of the hepatitis C virus genotype

The following matrices identify the regimens which are available for PBS prescription for eligible patients, based on the hepatitis C virus genotype and treatment history.

HEPATITIS C - NON-CIRRHOTIC PATIENTS

	TREATMENT NAÏVE	**TREATMENT EXPERIENCED**
Genotype 1	LEDIPASVIR + SOFOSBUVIR **[8 or 12 weeks]**[2] **OR** DACLATASVIR and SOFOSBUVIR **[12 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR **[12 weeks]** [3] **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV **[12 weeks]** [4] **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**	LEDIPASVIR + SOFOSBUVIR **[12 weeks]** **OR** DACLATASVIR and SOFOSBUVIR **[12 or 24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR **[12 weeks]** [3] **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV **[12 weeks]** [4] **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR and RBV **[16 weeks]** [5] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**
Genotype 2	SOFOSBUVIR and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**	SOFOSBUVIR and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**
Genotype 3	DACLATASVIR and SOFOSBUVIR **[12 weeks]** **OR** SOFOSBUVIR and RBV **[24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**	DACLATASVIR and SOFOSBUVIR **[12 weeks]** **OR** SOFOSBUVIR and RBV **[24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**
Genotype 4	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR and RBV **[16 weeks]** [5] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**
Genotype 5 & 6	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]**

KEY
PEG-IFN - peginterferon alfa-2a
RBV - ribavirin

[1] Medicines for the treatment of hepatitis C are listed for prescribing by authorised nurse practitioners under the General Schedule only. Medicines for the treatment of hepatitis C are not listed for prescribing by authorised nurse practitioners under the S100 Highly Specialised Drugs Program.

[2] [LEDIPASVIR + SOFOSBUVIR] for treatment-naïve, non-cirrhotic patients:
- consider treatment for 8 weeks where pre-treatment HCV RNA is less than 6 million IU/mL;
- otherwise treatment for 12 weeks where pre-treatment HCV RNA is 6 million IU/mL or greater.

[3] [PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR] for treatment-naïve and treatment experienced, non-cirrhotic patients, treatment for 12 weeks in patients with genotype 1b HCV.

[4] [PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV] for treatment-naïve and treatment experienced, non-cirrhotic patients, treatment for 12 weeks in patients with genotype 1a HCV.

[5] [GRAZOPREVIR + ELBASVIR and RBV] for treatment-experienced, non-cirrhotic and cirrhotic patients, treatment for 16 weeks in patients with genotype 1a or 4 HCV who have experienced on-treatment virologic failure to prior treatment.

HEPATITIS C – CIRRHOTIC PATIENTS

	TREATMENT NAÏVE	TREATMENT EXPERIENCED
Genotype 1	LEDIPASVIR + SOFOSBUVIR **[12 weeks]** **OR** DACLATASVIR and SOFOSBUVIR and RBV **[12 weeks]** **OR** DACLATASVIR and SOFOSBUVIR **[24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]	LEDIPASVIR + SOFOSBUVIR **[24 weeks]** **OR** DACLATASVIR and SOFOSBUVIR **[24 weeks]** **OR** DACLATASVIR and SOFOSBUVIR and RBV **[12 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV **[12 or 24 weeks]** [7] **OR** GRAZOPREVIR + ELBASVIR **[12 weeks]** **OR** GRAZOPREVIR + ELBASVIR and RBV **[16 weeks]** [5] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]
Genotype 2	SOFOSBUVIR and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]	SOFOSBUVIR and RBV **[12 weeks]** **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]
Genotype 3	SOFOSBUVIR and RBV **[24 weeks]** **OR** DACLATASVIR and SOFOSBUVIR **[24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** DACLATASVIR and SOFOSBUVIR and RBV **[12 or 24 weeks]** [8] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6,9]	DACLATASVIR and SOFOSBUVIR **[24 weeks]** **OR** SOFOSBUVIR and RBV **[24 weeks]** **OR** SOFOSBUVIR and PEG-IFN and RBV **[12 weeks]** **OR** DACLATASVIR and SOFOSBUVIR and RBV **[12 or 24 weeks]** [8] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6,9]
Genotype 4	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks] OR** GRAZOPREVIR + ELBASVIR **[12 weeks] OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks] OR** GRAZOPREVIR + ELBASVIR **[12 weeks] OR** GRAZOPREVIR + ELBASVIR and RBV **[16 weeks]** [5] **OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]
Genotype 5 & 6	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks] OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]	SOFOSBUVIR and PEG-IFN and RBV **[12 weeks] OR** SOFOSBUVIR + VELPATASVIR **[12 weeks]** [6]

KEY

PEG-IFN - peginterferon alfa-2a
RBV – ribavirin

[6] [SOFOSBUVIR + VELPATASVIR] for patients with decompensated cirrhosis:
- use in combination with ribavirin.

[7] [PARITAPREVIR + RITONAVIR + OMBITASVIR (&) DASABUVIR (&) RBV] for treatment-experienced, cirrhotic patients:
- consider treatment for 12 weeks in patients with genotype 1a HCV (except prior null responders to PEG-IFN and RBV) and genotype 1b HCV; or
- consider treatment for 24 weeks in patients with genotype 1a HCV who have had a previous null response to PEG-IFN and RBV.

[8] [DACLATASVIR and SOFOSBUVIR and RBV] for cirrhotic patients consider a 24 week regimen of where clinically appropriate.

[9] [SOFOSBUVIR + VELPATASVIR] for patients with genotype 3 infection with compensated cirrhosis:
- consider addition of ribavirin.

Pharmaceutical Benefits Schedules

Prescriber Bag

▪ ADRENALINE

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

3451P	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	22.58	Link Medical Products Pty Ltd [LM]

▪ ATROPINE SULFATE MONOHYDRATE

atropine sulfate monohydrate 600 microgram/mL injection, 10 x 1 mL ampoules

3453R	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	22.76	Pfizer Australia Pty Ltd [PF]

▪ BENZATROPINE

benzatropine mesilate 2 mg/2 mL injection, 10 x 2 mL vials

10016E	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	263.28	Benztropine Omega [FK]

▪ BENZYLPENICILLIN

benzylpenicillin 600 mg injection, 1 vial

3486L	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	5	*36.25	BenPen [CS]

OR

▪ PROCAINE BENZYLPENICILLIN (PROCAINE PENICILLIN)

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

3485K	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	85.18	Cilicaine [QA]

▪ BENZYLPENICILLIN

benzylpenicillin 3 g injection, 1 vial

3487M	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	19.78	BenPen [CS]

▪ CHLORPROMAZINE

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

3455W	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	22.70	Largactil [SW]

OR

▪ HALOPERIDOL

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

3456X	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	24.20	Serenace [QA]

▪ CLONAZEPAM

clonazepam 2.5 mg/mL oral liquid, 10 mL

3478C	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	‡1	14.84	Rivotril [RO]

▪ DEXAMETHASONE SODIUM PHOSPHATE

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

3472R	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	17.21	[a] Dexamethasone Mylan [AF]	[a] Hospira Pty Limited [PF]

OR

▪ HYDROCORTISONE SODIUM SUCCINATE

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

3470P	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	2	*20.89	Solu-Cortef [PF]

OR

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

3471Q	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	19.85	Solu-Cortef [PF]

▪ DIAZEPAM

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

3458B	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	17.11	Hospira Pty Limited [PF]

▪ DIPHTHERIA TOXOID + TETANUS TOXOID

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

10244E	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	136.39	MassBiologics tetanus and diphtheria toxoids adsorbed [CS]

OR

▪ DIPHTHERIA TOXOID + TETANUS TOXOID

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

3463G	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	2	*130.13	ADT Booster [CS]

▪ FUROSEMIDE (FRUSEMIDE)

furosemide (frusemide) 20 mg/2 mL injection, 5 x 2 mL ampoules

3466K	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	13.24	[a] Frusemide-Claris [AE] [a] Lasix [SW]	[a] Frusemide Sandoz [SZ]

▪ GLUCAGON HYDROCHLORIDE

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

3467L	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	50.97	GlucaGen Hypokit [NO]

▪ GLYCERYL TRINITRATE

glyceryl trinitrate 400 microgram/actuation oral spray, 200 actuations

3475X	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	‡1	23.01	Nitrolingual Pumpspray [SW]

▪ HYOSCINE BUTYLBROMIDE

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

3473T	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	23.43	[a] Buscopan [VZ]	[a] HYOSCINE BUTYLBROMIDE SXP [XC]

▪ LIGNOCAINE

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

10209H	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	39.16	Pfizer Australia Pty Ltd [PF]

▪ METHOXYFLURANE

methoxyflurane 999.9 mg/g inhalation solution, 3 mL

3489P	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
	1	43.26	Penthrox [DV]

▪ METOCLOPRAMIDE

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

3476Y	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	16.80	Maxolon [IA]

OR

▪ PROCHLORPERAZINE

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

3477B	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	20.77	Stemetil [SW]

▪ MIDAZOLAM

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

10178Q	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	40.32	Pfizer Australia Pty Ltd [PF]

▪ MORPHINE

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

3480E	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	23.92	Hospira Pty Limited [PF]

OR

morphine hydrochloride 20 mg/mL injection, 5 x 1 mL ampoules

10868B	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	23.78	Morphine Juno [JU]

OR

morphine hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

10862Q	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	20.42	Morphine Juno [JU]

OR

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

3479D	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	21.82	Hospira Pty Limited [PF]

▪ NALOXONE

naloxone hydrochloride 400 microgram/mL injection, 5 x 1 mL ampoules

10786Q	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	*153.87	[a] Naloxone Hydrochloride (DBL) [PF]	[a] Naloxone Juno [JU]

OR

naloxone hydrochloride 400 microgram/mL injection, 10 x 1 mL ampoules

11233F	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	1	153.88	[a] NARCAN [PL]

▪ OXYTOCIN

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

10251M	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
	1	61.09	Oxytocin Sandoz [SZ]

▪ PHYTOMENADIONE

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

10213M	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
	1	24.58	Konakion MM [RO]

▪ PROMETHAZINE

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

3488N	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	2	*38.67	Hospira Pty Limited [PF]

▪ SALBUTAMOL

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

3496B	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	15.09	[a] APO-Salbutamol [TX]	[a] Butamol 2.5 [QA]
			[a] Salbutamol Actavis [EA]	[a] Salbutamol AN [ED]
			[a] Salbutamol Sandoz [SZ]	
		15.34	[a] Asmol 2.5 uni-dose [AF]	

OR

salbutamol 100 microgram/actuation pressurised inhalation, 200 actuations

3495Y	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	‡1	14.80	[a] Asmol CFC-free [AL]
		16.57	[a] Ventolin CFC-free [GK]

OR

salbutamol 2.5 mg/2.5 mL inhalation solution, 20 x 2.5 mL ampoules

11125M	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	‡1	14.43	Ventolin Nebules [GK]

▪ SALBUTAMOL

salbutamol 5 mg/2.5 mL inhalation solution, 20 x 2.5 mL ampoules

11088N	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer
NP	‡1	14.56	Ventolin Nebules [GK]

OR

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

3497C	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	15.30	[a] APO-Salbutamol [TX]	[a] Butamol 5 [QA]
			[a] Salbutamol Actavis [EA]	[a] Salbutamol AN [ED]
			[a] Salbutamol Sandoz [SZ]	
		15.55	[a] Asmol 5 uni-dose [AF]	

▪ TRAMADOL

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

3484J	Max.Qty Packs	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	13.94	[a] Tramadol ACT [EA]	[a] Tramadol Sandoz [SZ]
			[a] Tramal 100 [CS]	

General Pharmaceutical Benefits

ALIMENTARY TRACT AND METABOLISM 29
STOMATOLOGICAL PREPARATIONS 29
STOMATOLOGICAL PREPARATIONS 29
DRUGS FOR ACID RELATED DISORDERS 29
DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD) 29
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS 36
BELLADONNA AND DERIVATIVES, PLAIN 36
PROPULSIVES 36
ANTIEMETICS AND ANTINAUSEANTS 36
ANTIEMETICS AND ANTINAUSEANTS 36
BILE AND LIVER THERAPY 43
BILE THERAPY 43
DRUGS FOR CONSTIPATION 43
DRUGS FOR CONSTIPATION 43
ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS 47
INTESTINAL ANTIINFECTIVES 47
ELECTROLYTES WITH CARBOHYDRATES 48
ANTIPROPULSIVES 48
INTESTINAL ANTIINFLAMMATORY AGENTS 48
DIGESTIVES, INCL. ENZYMES 52
DIGESTIVES, INCL. ENZYMES 52
DRUGS USED IN DIABETES 54
INSULINS AND ANALOGUES 54
BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS 55
VITAMINS 79
VITAMIN A AND D, INCL. COMBINATIONS OF THE TWO 79
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12 79
MINERAL SUPPLEMENTS 79
CALCIUM 79
POTASSIUM 80
OTHER MINERAL SUPPLEMENTS 80
ANABOLIC AGENTS FOR SYSTEMIC USE 80
ANABOLIC STEROIDS 80
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS 81
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS 81

BLOOD AND BLOOD FORMING ORGANS 82
ANTITHROMBOTIC AGENTS 82
ANTITHROMBOTIC AGENTS 82
ANTIHEMORRHAGICS 97
ANTIFIBRINOLYTICS 97
ANTIANEMIC PREPARATIONS 98
IRON PREPARATIONS 98
VITAMIN B12 AND FOLIC ACID 99
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS 100
BLOOD AND RELATED PRODUCTS 100
OTHER HEMATOLOGICAL AGENTS 100
OTHER HEMATOLOGICAL AGENTS 100

CARDIOVASCULAR SYSTEM 100
CARDIAC THERAPY 100
CARDIAC GLYCOSIDES 100
ANTIARRHYTHMICS, CLASS I AND III 101
CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES 102
VASODILATORS USED IN CARDIAC DISEASES 103
OTHER CARDIAC PREPARATIONS 105
ANTIHYPERTENSIVES 105
ANTIADRENERGIC AGENTS, CENTRALLY ACTING 105
ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING 106
ARTERIOLAR SMOOTH MUSCLE, AGENTS ACTING ON 106
DIURETICS 106
LOW-CEILING DIURETICS, THIAZIDES 106
LOW-CEILING DIURETICS, EXCL. THIAZIDES 106
HIGH-CEILING DIURETICS 107
POTASSIUM-SPARING AGENTS 108
DIURETICS AND POTASSIUM-SPARING AGENTS IN COMBINATION 108
PERIPHERAL VASODILATORS 109
PERIPHERAL VASODILATORS 109
BETA BLOCKING AGENTS 109
BETA BLOCKING AGENTS 109
CALCIUM CHANNEL BLOCKERS 112
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY VASCULAR EFFECTS 112
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT CARDIAC EFFECTS 114
AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM 115
ACE INHIBITORS, PLAIN 115
ACE INHIBITORS, COMBINATIONS 119
ANGIOTENSIN II ANTAGONISTS, PLAIN 122
ANGIOTENSIN II ANTAGONISTS, COMBINATIONS 124
LIPID MODIFYING AGENTS 131
LIPID MODIFYING AGENTS, PLAIN 131
LIPID MODIFYING AGENTS, COMBINATIONS 144

DERMATOLOGICALS 161
ANTIFUNGALS FOR DERMATOLOGICAL USE 161
ANTIFUNGALS FOR TOPICAL USE 161

ANTIFUNGALS FOR SYSTEMIC USE ... 162
ANTIPSORIATICS ... 163
ANTIPSORIATICS FOR TOPICAL USE ... 163
ANTIPSORIATICS FOR SYSTEMIC USE ... 164
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE ... 164
CHEMOTHERAPEUTICS FOR TOPICAL USE ... 164
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS ... 164
CORTICOSTEROIDS, PLAIN ... 164
ANTI-ACNE PREPARATIONS ... 174
ANTI-ACNE PREPARATIONS FOR TOPICAL USE ... 174
ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE ... 174
OTHER DERMATOLOGICAL PREPARATIONS ... 175
OTHER DERMATOLOGICAL PREPARATIONS ... 175

GENITO URINARY SYSTEM AND SEX HORMONES ... 176

OTHER GYNECOLOGICALS ... 176
CONTRACEPTIVES FOR TOPICAL USE ... 176
OTHER GYNECOLOGICALS ... 176
SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM ... 178
HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE ... 178
ANDROGENS ... 179
ESTROGENS ... 181
PROGESTOGENS ... 183
PROGESTOGENS AND ESTROGENS IN COMBINATION ... 183
GONADOTROPINS AND OTHER OVULATION STIMULANTS ... 184
ANTIANDROGENS ... 186
OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM ... 187
UROLOGICALS ... 188
UROLOGICALS ... 188
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY ... 189

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS ... 189

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES ... 189
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES ... 189
POSTERIOR PITUITARY LOBE HORMONES ... 190
HYPOTHALAMIC HORMONES ... 191
CORTICOSTEROIDS FOR SYSTEMIC USE ... 191
CORTICOSTEROIDS FOR SYSTEMIC USE, PLAIN ... 191
THYROID THERAPY ... 195
THYROID PREPARATIONS ... 195
ANTITHYROID PREPARATIONS ... 196
PANCREATIC HORMONES ... 197
GLYCOGENOLYTIC HORMONES ... 197
CALCIUM HOMEOSTASIS ... 197
PARATHYROID HORMONES AND ANALOGUES ... 197
ANTI-PARATHYROID AGENTS ... 198

ANTIINFECTIVES FOR SYSTEMIC USE ... 198

ANTIBACTERIALS FOR SYSTEMIC USE ... 198
TETRACYCLINES ... 198
BETA-LACTAM ANTIBACTERIALS, PENICILLINS ... 200

OTHER BETA-LACTAM ANTIBACTERIALS ... 207
SULFONAMIDES AND TRIMETHOPRIM ... 213
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS ... 214
AMINOGLYCOSIDE ANTIBACTERIALS ... 217
QUINOLONE ANTIBACTERIALS ... 218
OTHER ANTIBACTERIALS ... 220
ANTIMYCOTICS FOR SYSTEMIC USE ... 222
ANTIMYCOTICS FOR SYSTEMIC USE ... 222
ANTIMYCOBACTERIALS ... 228
DRUGS FOR TREATMENT OF TUBERCULOSIS ... 228
DRUGS FOR TREATMENT OF LEPRA ... 228
ANTIVIRALS FOR SYSTEMIC USE ... 229
DIRECT ACTING ANTIVIRALS ... 229
VACCINES ... 238
BACTERIAL VACCINES ... 238

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS ... 238

ANTINEOPLASTIC AGENTS ... 238
ALKYLATING AGENTS ... 238
ANTIMETABOLITES ... 240
PLANT ALKALOIDS AND OTHER NATURAL PRODUCTS ... 242
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES ... 242
OTHER ANTINEOPLASTIC AGENTS ... 242
ENDOCRINE THERAPY ... 295
HORMONES AND RELATED AGENTS ... 295
HORMONE ANTAGONISTS AND RELATED AGENTS ... 299
IMMUNOSTIMULANTS ... 304
IMMUNOSTIMULANTS ... 304
IMMUNOSUPPRESSANTS ... 308
IMMUNOSUPPRESSANTS ... 308

MUSCULO-SKELETAL SYSTEM ... 558

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS ... 558
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS ... 558
SPECIFIC ANTIRHEUMATIC AGENTS ... 564
MUSCLE RELAXANTS ... 565
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS ... 565
MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS ... 565
ANTIGOUT PREPARATIONS ... 566
ANTIGOUT PREPARATIONS ... 566
DRUGS FOR TREATMENT OF BONE DISEASES ... 567
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION ... 567

NERVOUS SYSTEM ... 576

ANALGESICS ... 576
OPIOIDS ... 576
OTHER ANALGESICS AND ANTIPYRETICS ... 592
ANTIMIGRAINE PREPARATIONS ... 594
ANTIEPILEPTICS ... 597
ANTIEPILEPTICS ... 597

ANTI-PARKINSON DRUGS 609
ANTICHOLINERGIC AGENTS 609
DOPAMINERGIC AGENTS 609
PSYCHOLEPTICS 615
ANTIPSYCHOTICS 615
ANXIOLYTICS 631
HYPNOTICS AND SEDATIVES 633
PSYCHOANALEPTICS 635
ANTIDEPRESSANTS 635
PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS 644
ANTI-DEMENTIA DRUGS 649
OTHER NERVOUS SYSTEM DRUGS 656
PARASYMPATHOMIMETICS 656
DRUGS USED IN ADDICTIVE DISORDERS 656
OTHER NERVOUS SYSTEM DRUGS 660

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS 662

ANTIPROTOZOALS 662
AGENTS AGAINST AMOEBIASIS AND OTHER PROTOZOAL DISEASES 662
ANTIMALARIALS 662
ANTHELMINTICS 663
ANTITREMATODALS 663
ANTINEMATODAL AGENTS 663
ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS 664
ECTOPARASITICIDES, INCL. SCABICIDES 664

RESPIRATORY SYSTEM 665

NASAL PREPARATIONS 665
DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE 665
DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 665
ADRENERGICS, INHALANTS 665
OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS 671
ADRENERGICS FOR SYSTEMIC USE 674
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 675
COUGH AND COLD PREPARATIONS 677
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS 677
ANTIHISTAMINES FOR SYSTEMIC USE 677
ANTIHISTAMINES FOR SYSTEMIC USE 677

SENSORY ORGANS 677

OPHTHALMOLOGICALS 677
ANTIINFECTIVES 677
ANTIINFLAMMATORY AGENTS 679
ANTIGLAUCOMA PREPARATIONS AND MIOTICS 682
MYDRIATICS AND CYCLOPLEGICS 688
OCULAR VASCULAR DISORDER AGENTS 689

OTHER OPHTHALMOLOGICALS 698
OTOLOGICALS 706
ANTIINFECTIVES 706
CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION 707
OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS 707
ANTIINFECTIVES 707

VARIOUS 707

ALLERGENS 707
ALLERGENS 707
ALL OTHER THERAPEUTIC PRODUCTS 708
ALL OTHER THERAPEUTIC PRODUCTS 708
DIAGNOSTIC AGENTS 711
URINE TESTS 711
GENERAL NUTRIENTS 711
OTHER NUTRIENTS 711

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antiinfectives and antiseptics for local oral treatment

AMPHOTERICIN B

amphotericin B 10 mg lozenge, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2931G NP	1	1	..	15.72	16.93	Fungilin [QA]

amphotericin B 10 mg lozenge, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3306B DP	1	..	..	15.72	16.93	Fungilin [QA]

Other agents for local oral treatment

BENZYDAMINE

Restricted benefit

Mucositis

Clinical criteria:

- The condition must be radiation induced.

benzydamine hydrochloride 0.15% mouthwash, 500 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1121B NP	‡1	1	..	24.18	25.39	Difflam [IA]

BENZYDAMINE

Restricted benefit

Mucositis

Clinical criteria:

- The condition must be radiation induced.

benzydamine hydrochloride 0.15% mouthwash, 500 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5032W DP	‡1	..	..	24.18	25.39	Difflam [IA]

DRUGS FOR ACID RELATED DISORDERS

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

H2-receptor antagonists

CIMETIDINE

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

cimetidine 400 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1158Y NP	1	5	..	20.09	21.30	Magicul 400 [AF]

FAMOTIDINE

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

famotidine 40 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2488Y NP	1	5	..	14.94	16.15	[a] Ausfam 40 [RW] [a] Famotidine Sandoz [SZ]	[a] Famotidine AN [EA] [a] GenRx Famotidine [GX]

famotidine 20 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2487X NP	1	5	..	14.94	16.15	[a] Ausfam 20 [RW] [a] Famotidine Sandoz [SZ]	[a] Famotidine AN [EA] [a] GenRx Famotidine [GX]

▪ NIZATIDINE

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

nizatidine 300 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1504E NP	1	5	..	21.53	22.74	[a] Nizac [RF]	[a] Tacidine [AF]
			[B]6.61	28.14	22.74	[a] Tazac [RW]	

nizatidine 150 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1505F NP	1	5	..	21.53	22.74	[a] Nizac [RF]	[a] Tacidine [AF]
			[B]6.61	28.14	22.74	[a] Tazac [RW]	

▪ RANITIDINE

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

ranitidine 300 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1977C NP	1	5	..	14.55	15.76	[a] APO-Ranitidine [TX] [a] Chem mart Ranitidine [CH] [a] Ranitidine GH [GQ] [a] Terry White Chemists Ranitidine [TW]	[a] Ausran [RW] [a] Rani 2 [AF] [a] Ranitidine Sandoz [SZ]
			[B]1.68	16.23	15.76	[a] Zantac [AS]	

ranitidine 150 mg/10 mL oral liquid, 300 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8162N NP	2	5	..	*26.83	28.04	Zantac Syrup [AS]

▪ RANITIDINE

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

Note Pharmaceutical benefits that have the form ranitidine tablet 150 mg (as hydrochloride) and pharmaceutical benefits that have the form ranitidine tablet, effervescent, 150 mg (as hydrochloride) are equivalent for the purposes of substitution.

ranitidine 150 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1978D NP MW	1	5	..	14.55	15.76	[a] APO-Ranitidine [TX] [a] Chem mart Ranitidine [CH] [a] Ranitidine AN [EA] [a] Ranitidine Sandoz [SZ] [a] Ulcaid [RA]	[a] Ausran [RW] [a] Rani 2 [AF] [a] Ranitidine GH [GQ] [a] Terry White Chemists Ranitidine [TW]
			[B]1.68	16.23	15.76	[a] Zantac [AS]	

ranitidine 150 mg effervescent tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1937Y NP	2	5	[B]1.16	*16.15	16.20	[a] Zantac [AS]

Proton pump inhibitors

▪ ESOMEPRAZOLE

Note Pharmaceutical benefits that have the form esomeprazole tablet 40 mg and pharmaceutical benefits that have the form esomeprazole capsule 40 mg are equivalent for the purposes of substitution.

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

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

Restricted benefit

Gastro-oesophageal reflux disease

Clinical criteria:

- The treatment must be for the healing of gastro-oesophageal reflux disease.

esomeprazole 40 mg enteric tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8601Q NP	1	1	..	27.76	28.97	[a] Esomeprazole Apotex [TX] [a] Esomeprazole GxP [AF] [a] Esomeprazole Sandoz [SZ] [a] Nexazole [RW]	[a] Esomeprazole GH [GQ] [a] Esomeprazole RBX [RA] [a] Esomeprazole SZ [HX] [a] Nexium [AP]

						[a] Nexole [RF]	[a] Pharmacor Esomeprazole [CR]

esomeprazole 40 mg capsule, 30

10330Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	27.76	28.97	[a] Esomeprazole ACTAVIS [EA]	[a] Noxicid Caps [AL]

▪ ESOMEPRAZOLE

Note Pharmaceutical benefits that have the form esomeprazole tablet 40 mg and pharmaceutical benefits that have the form esomeprazole capsule 40 mg are equivalent for the purposes of substitution.

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

Authority required

Pathological hypersecretory conditions including Zollinger-Ellison syndrome and idiopathic hypersecretion

Authority required

Scleroderma oesophagus

esomeprazole 40 mg enteric tablet, 30

3401B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.76	28.97	[a] Esomeprazole Apotex [TX] [a] Esomeprazole GxP [AF] [a] Esomeprazole Sandoz [SZ] [a] Nexazole [RW] [a] Nexole [RF]	[a] Esomeprazole GH [GQ] [a] Esomeprazole RBX [RA] [a] Esomeprazole SZ [HX] [a] Nexium [AP] [a] Pharmacor Esomeprazole [CR]

esomeprazole 40 mg capsule, 30

10331R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.76	28.97	[a] Esomeprazole ACTAVIS [EA]	[a] Noxicid Caps [AL]

▪ ESOMEPRAZOLE

Note Helicobacter pylori eradication therapy should be considered.

Note Pharmaceutical benefits that have the form esomeprazole tablet 20 mg and pharmaceutical benefits that have the form esomeprazole capsule 20 mg are equivalent for the purposes of substitution.

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

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

Restricted benefit

Gastric ulcer

Treatment Phase: Initial treatment

esomeprazole 20 mg capsule, 30

10295W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	20.92	22.13	[a] Esomeprazole ACTAVIS [EA]	[a] Noxicid Caps [AL]

esomeprazole 20 mg enteric tablet, 30

8886Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	20.92	22.13	[a] Esomeprazole Apotex [TX] [a] Esomeprazole GxP [AF] [a] Esomeprazole Sandoz [SZ] [a] Nexazole [RW] [a] Nexole [RF]	[a] Esomeprazole GH [GQ] [a] Esomeprazole RBX [RA] [a] Esomeprazole SZ [HX] [a] Nexium [AP] [a] Pharmacor Esomeprazole [CR]

▪ ESOMEPRAZOLE

Note Pharmaceutical benefits that have the form esomeprazole tablet 20 mg and pharmaceutical benefits that have the form esomeprazole capsule 20 mg are equivalent for the purposes of substitution.

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

Restricted benefit

Gastro-oesophageal reflux disease

Clinical criteria:

- The treatment must be maintenance therapy, **AND**
- The condition must be healed.

Restricted benefit

Scleroderma oesophagus

Restricted benefit

Pathological hypersecretory conditions including Zollinger-Ellison syndrome and idiopathic hypersecretion

esomeprazole 20 mg capsule, 30

10343J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.92	22.13	[a] Esomeprazole ACTAVIS [EA]	[a] Noxicid Caps [AL]

esomeprazole 20 mg enteric tablet, 30

8600P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.92	22.13	[a] Esomeprazole Apotex [TX] [a] Esomeprazole GxP [AF] [a] Esomeprazole Sandoz [SZ] [a] Nexazole [RW] [a] Nexole [RF]	[a] Esomeprazole GH [GQ] [a] Esomeprazole RBX [RA] [a] Esomeprazole SZ [HX] [a] Nexium [AP] [a] Pharmacor Esomeprazole [CR]

▪ LANSOPRAZOLE

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

lansoprazole 15 mg orally disintegrating tablet, 28

9331D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.23	15.44	[a] APO-Lansoprazole ODT [TX] [a] Zopral ODT [AF]	[a] Lansoprazole ODT GH [GQ]
			[B]3.98	18.21	15.44	[a] Zoton FasTabs [PF]	

lansoprazole 15 mg enteric capsule, 30

8198L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.46	15.67	Zopral [AF]

▪ LANSOPRAZOLE

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

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

lansoprazole 30 mg orally disintegrating tablet, 28

9478W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.72	17.93	[a] APO-Lansoprazole ODT [TX] [a] Zopral ODT [AF]	[a] Lansoprazole ODT GH [GQ]
			[B]3.99	20.71	17.93	[a] Zoton FasTabs [PF]	

lansoprazole 30 mg enteric capsule, 28

2241Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.72	17.93	[a] APO-Lansoprazole [TX] [a] Zopral [AF]	[a] Lanzopran [RA]

▪ LANSOPRAZOLE

Note Helicobacter pylori eradication therapy should be considered.

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

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

Restricted benefit

Peptic ulcer

Treatment Phase: Initial treatment

lansoprazole 30 mg orally disintegrating tablet, 28

9477T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	16.72	17.93	[a] APO-Lansoprazole ODT [TX] [a] Zopral ODT [AF]	[a] Lansoprazole ODT GH [GQ]
			[B]3.99	20.71	17.93	[a] Zoton FasTabs [PF]	

lansoprazole 30 mg enteric capsule, 28

2240X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	16.72	17.93	[a] APO-Lansoprazole [TX] [a] Zopral [AF]	[a] Lanzopran [RA]

▪ OMEPRAZOLE

Restricted benefit
Gastro-oesophageal reflux disease
Restricted benefit
Scleroderma oesophagus
Restricted benefit
Zollinger-Ellison syndrome

omeprazole 10 mg enteric tablet, 30

8332M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	14.71	15.92	Losec Tablets [AP]

▪ OMEPRAZOLE

Note Helicobacter pylori eradication therapy should be considered.
Note Pharmaceutical benefits that have the forms omeprazole tablet 20 mg, omeprazole capsule 20 mg and omeprazole tablet 20 mg (as magnesium) are equivalent for the purposes of substitution.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Peptic ulcer
Treatment Phase: Initial treatment

omeprazole 20 mg enteric tablet, 30

8331L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	1	..	15.52	16.73	[a] APO-Omeprazole [TX] [a] Meprazol [SZ] [a] Omeprazole generichealth [GQ] [a] Pharmacor Omeprazole [CR]	[a] Chem mart Omeprazole [CH] [a] Omeprazole AN [EA] [a] Ozmep [ZP] [a] Terry White Chemists Omeprazole [TW]

omeprazole 20 mg enteric tablet, 30

9109K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	1	..	15.52	16.73	[a] Acimax Tablets [AL] [a] Omeprazole Sandoz [SZ]	[a] Omepral [ZA]
		[B]3.06	18.58	16.73	[a] Losec Tablets [AP]	

omeprazole 20 mg capsule, 30

1326T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	1	..	15.52	16.73	[a] APO-Omeprazole [TX] [a] Omeprazole Sandoz [HX] [a] Pharmacor Omeprazole 20 [CR]	[a] Maxor [AF] [a] Pemzo [RW] [a] Probitor [SZ]

▪ OMEPRAZOLE

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

Restricted benefit
Gastro-oesophageal reflux disease
Restricted benefit
Scleroderma oesophagus
Restricted benefit
Zollinger-Ellison syndrome

omeprazole 20 mg enteric tablet, 30

8333N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	15.52	16.73	[a] APO-Omeprazole [TX] [a] Meprazol [SZ] [a] Omeprazole generichealth [GQ] [a] Pharmacor Omeprazole [CR]	[a] Chem mart Omeprazole [CH] [a] Omeprazole AN [EA] [a] Ozmep [ZP] [a] Terry White Chemists Omeprazole [TW]

omeprazole 20 mg enteric tablet, 30

9110L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	15.52	16.73	[a] Acimax Tablets [AL] [a] Omeprazole Sandoz [SZ]	[a] Omepral [ZA]
		[B]3.06	18.58	16.73	[a] Losec Tablets [AP]	

omeprazole 20 mg capsule, 30

1327W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.52	16.73	[a] APO-Omeprazole [TX] [a] Omeprazole Sandoz [HX] [a] Pharmacor Omeprazole 20 [CR]	[a] Maxor [AF] [a] Pemzo [RW] [a] Probitor [SZ]

▪ PANTOPRAZOLE

Note Helicobacter pylori eradication therapy should be considered.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Peptic ulcer
Treatment Phase: Initial treatment

pantoprazole 40 mg enteric tablet, 30

8007K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.64	14.85	[a] APO-Pantoprazole [TX] [a] I-Pantoprazole [CR] [a] Panthron [ER] [a] Pantofast 40 [RZ] [a] Pantoprazole AN [EA] [a] Pantoprazole Sandoz [SZ] [a] Somac [NQ] [a] Topra 40 [DO]	[a] APOTEX-Pantoprazole [GX] [a] Ozpan [RA] [a] Panto [TK] [a] Pantoprazole Actavis [ED] [a] Pantoprazole GH [GQ] [a] Salpraz [AF] [a] Sozol [RW]

pantoprazole 40 mg enteric coated granules, 30 sachets

9423Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	32.21	33.42	Somac [NQ]

▪ PANTOPRAZOLE

Restricted benefit
Gastro-oesophageal reflux disease
Restricted benefit
Scleroderma oesophagus
Restricted benefit
Zollinger-Ellison syndrome

pantoprazole 20 mg enteric tablet, 30

8399C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.34	13.55	[a] APO-Pantoprazole [TX] [a] Ozpan [RA] [a] Panto [TK] [a] Pantoprazole AN [EA] [a] Pantoprazole Sandoz [SZ] [a] Somac [NQ]	[a] APOTEX-Pantoprazole [GX] [a] Panthron [ER] [a] Pantofast 20 [RZ] [a] Pantoprazole GH [GQ] [a] Salpraz [AF] [a] Sozol [RW]

pantoprazole 40 mg enteric tablet, 30

8008L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.64	14.85	[a] APO-Pantoprazole [TX] [a] I-Pantoprazole [CR] [a] Panthron [ER] [a] Pantofast 40 [RZ] [a] Pantoprazole AN [EA] [a] Pantoprazole Sandoz [SZ] [a] Somac [NQ] [a] Topra 40 [DO]	[a] APOTEX-Pantoprazole [GX] [a] Ozpan [RA] [a] Panto [TK] [a] Pantoprazole Actavis [ED] [a] Pantoprazole GH [GQ] [a] Salpraz [AF] [a] Sozol [RW]

pantoprazole 40 mg enteric coated granules, 30 sachets

9424B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	32.21	33.42	Somac [NQ]

▪ RABEPRAZOLE

Restricted benefit
Gastro-oesophageal reflux disease
Restricted benefit
Scleroderma oesophagus

rabeprazole sodium 20 mg enteric tablet, 30

8508T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.13	15.34	[a] APO-Rabeprazole [TX] [a] Parbezol [RW] [a] Rabeprazole AN [EA] [a] Rabeprazole generichealth [GQ] [a] Rabeprazole SUN [RN] [a] Terry White Chemists Rabeprazole [TW]	[a] Chem mart Rabeprazole [CH] [a] Parzol 20 [ZP] [a] Rabeprazole-DRLA [RZ] [a] Rabeprazole Sandoz [SZ] [a] Razit 20 [DO] [a] Zabep [AL]
			[B]3.95	18.08	15.34	[a] Pariet [JC]	

rabeprazole sodium 10 mg enteric tablet, 28

8507R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.13	15.34	[a] APO-Rabeprazole [TX] [a] Parzol 10 [ZP] [a] Rabeprazole-DRLA [RZ] [a] Rabeprazole Sandoz [SZ]	[a] Parbezol [RW] [a] Rabeprazole AN [EA] [a] Rabeprazole generichealth [GQ] [a] Razit 10 [DO]
			[B]3.95	18.08	15.34	[a] Pariet [JC]	

▪ RABEPRAZOLE

Note Helicobacter pylori eradication therapy should be considered.

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

Restricted benefit

Peptic ulcer

Treatment Phase: Initial treatment

rabeprazole sodium 20 mg enteric tablet, 30

8509W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.13	15.34	[a] APO-Rabeprazole [TX] [a] Parbezol [RW] [a] Rabeprazole AN [EA] [a] Rabeprazole generichealth [GQ] [a] Rabeprazole SUN [RN] [a] Terry White Chemists Rabeprazole [TW]	[a] Chem mart Rabeprazole [CH] [a] Parzol 20 [ZP] [a] Rabeprazole-DRLA [RZ] [a] Rabeprazole Sandoz [SZ] [a] Razit 20 [DO] [a] Zabep [AL]
			[B]3.95	18.08	15.34	[a] Pariet [JC]	

Combinations for eradication of Helicobacter pylori

▪ ESOMEPRAZOLE (&) CLARITHROMYCIN (&) AMOXICILLIN

Note Pharmaceutical benefits that have the form pack containing 14 tablets (enteric coated) containing esomeprazole 20 mg (as magnesium trihydrate), 14 tablets clarithromycin 500 mg and 28 capsules amoxycillin 500 mg (as trihydrate) and pack containing 14 tablets (enteric coated) containing esomeprazole 20 mg (as magnesium), 14 tablets clarithromycin 500 mg and 28 capsules amoxycillin 500 mg (as trihydrate) are equivalent for the purposes of substitution.

Restricted benefit

Eradication of Helicobacter pylori

Clinical criteria:

- The condition must be associated with peptic ulcer disease.

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

10759G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	40.67	39.50	[a] ESOMEPRAZOLE SANDOZ Hp7 [SZ]

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

8738X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	40.67	39.50	[a] Nexium Hp7 [AP]

Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)

▪ SUCRALFATE

sucralfate 1 g tablet, 120

2055E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	26.68	27.89	Carafate [AS]

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, tertiary amines

ATROPINE SULFATE MONOHYDRATE

atropine sulfate monohydrate 600 microgram/mL injection, 10 x 1 mL ampoules

5022H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	22.76	23.97	Pfizer Australia Pty Ltd [PF]

ATROPINE SULFATE MONOHYDRATE

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

atropine sulfate monohydrate 600 microgram/mL injection, 10 x 1 mL ampoules

1089H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	22.76	23.97	Pfizer Australia Pty Ltd [PF]

PROPULSIVES

Propulsives

DOMPERIDONE

domperidone 10 mg tablet, 25

1347X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	13.13	14.34	Motilium [JC]

METOCLOPRAMIDE

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

1206L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	1	..	..	16.80	18.01	Maxolon [IA]

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

5153F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	16.80	18.01	Maxolon [IA]

metoclopramide hydrochloride 10 mg tablet, 25

1207M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	12.22	13.43	[a] APO-Metoclopramide [TX] [a] Metoclopramide AN [EA] [a] Pramin [AF]	[a] EMEXLON [RW] [a] Metoclopramide RBX [RA]
			[B]1.91	14.13	13.43	[a] Maxolon [IA]	

metoclopramide hydrochloride 10 mg tablet, 25

5151D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.22	13.43	[a] APO-Metoclopramide [TX] [a] Metoclopramide AN [EA] [a] Pramin [AF]	[a] EMEXLON [RW] [a] Metoclopramide RBX [RA]
			[B]1.91	14.13	13.43	[a] Maxolon [IA]	

ANTIEMETICS AND ANTINAUSEANTS

ANTIEMETICS AND ANTINAUSEANTS

Serotonin (5HT3) antagonists

GRANISETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

granisetron 3 mg/3 mL injection, 3 mL ampoule

8729K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.15	14.36	[a] Granisetron-AFT [AE] [a] Kytril [IX]	[a] Granisetron Kabi [PK]

▪ GRANISETRON

Authority required (STREAMLINED)

4092

Nausea and vomiting

Clinical criteria:

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

granisetron 3 mg/3 mL injection, 3 mL ampoule

8730L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.15	14.36	[a] Granisetron-AFT [AE] [a] Kytril [IX]	[a] Granisetron Kabi [PK]

▪ GRANISETRON

Authority required (STREAMLINED)

4102

Nausea and vomiting

Clinical criteria:

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

granisetron 2 mg tablet, 5

8873B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	55.66	39.50	Kytril [IX]

▪ GRANISETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

granisetron 2 mg tablet, 1

8728J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*28.91	30.12	Kytril [IX]

▪ NETUPITANT + PALONOSETRON

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

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

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

Authority required (STREAMLINED)

5991

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with dexamethasone, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following agents: altretamine; carmustine; cisplatin when a single dose constitutes a cycle of chemotherapy; cyclophosphamide at a dose of 1500 mg per square metre per day or greater; dacarbazine; procarbazine when a single dose constitutes a cycle of chemotherapy; streptozocin.

No more than 1 capsule of 300 mg netupitant/0.5 mg palonosetron fixed dose combination will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)

5994

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat breast cancer, **AND**
- The treatment must be in combination with dexamethasone, **AND**
- Patient must be scheduled to be co-administered cyclophosphamide and an anthracycline.

No more than 1 capsule of 300 mg netupitant/0.5 mg palonosetron fixed dose combination will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)

6937

Nausea and vomiting

Clinical criteria:

- The condition must be associated with moderately emetogenic cytotoxic chemotherapy being used to treat malignancy,

AND

- The treatment must be in combination with dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must have had a prior episode of chemotherapy induced nausea or vomiting, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following intravenous chemotherapy agents: arsenic trioxide; azacitidine; cyclophosphamide at a dose of less than 1500 mg per square metre per day; cytarabine at a dose of greater than 1 g per square metre per day; dactinomycin; daunorubicin; doxorubicin; epirubicin; fotemustine; idarubicin; ifosfamide; irinotecan; melphalan; methotrexate at a dose of 250 mg to 1 g per square metre; raltitrexed.

No more than 1 capsule of 300 mg netupitant/0.5 mg palonosetron fixed dose combination will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)

6879

Nausea and vomiting

Clinical criteria:

- The condition must be associated with moderately emetogenic cytotoxic chemotherapy being used to treat malignancy,

AND

- The treatment must be in combination with dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes either carboplatin or oxaliplatin.

No more than 1 capsule of 300 mg netupitant/0.5 mg palonosetron fixed dose combination will be authorised per cycle of cytotoxic chemotherapy.

netupitant 300 mg + palonosetron 500 microgram capsule, 1

10731T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	115.56	39.50	Akynzeo [MF]

▪ ONDANSETRON

Authority required (STREAMLINED)

4102

Nausea and vomiting

Clinical criteria:

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

ondansetron 8 mg tablet, 10

1595Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	25.48	26.69	[a] APO-Ondansetron [TX] [a] Ondansetron-DRLA [RZ] [a] Onsetron 8 [ZP] [a] Zofran [AS]	[a] Ondansetron AN [EA] [a] Ondansetron SZ [HX] [a] Zilfojim 8 [DO]

ondansetron 4 mg/5 mL oral liquid, 50 mL

8233H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	97.94	39.50	Zofran syrup 50 mL [AS]

ondansetron 4 mg tablet, 10

1594X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	20.26	21.47	[a] APO-Ondansetron [TX] [a] Ondansetron-DRLA [RZ] [a] Onsetron 4 [ZP] [a] Zofran [AS]	[a] Ondansetron AN [EA] [a] Ondansetron SZ [HX] [a] Zilfojim 4 [DO]

▪ ONDANSETRON

Authority required (STREAMLINED)

4092

Nausea and vomiting

Clinical criteria:

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

ondansetron 8 mg/4 mL injection, 4 mL ampoule

1597C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.64	12.85	[a] Ondansetron Alphapharm [AF]	[a] Onsetron [ZP]

ondansetron 4 mg/2 mL injection, 2 mL ampoule

1596B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.43	12.64	[a] Ondansetron Alphapharm [AF]	[a] Onsetron [ZP]

▪ ONDANSETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

ondansetron 8 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8225X NP	1	..	..	16.84	18.05	[a] APO-Ondansetron [TX] [a] Ondansetron-DRLA [RZ] [a] Onsetron 8 [ZP]	[a] Ondansetron AN [EA] [a] Ondansetron SZ [HX] [a] Zofran [AS]

ondansetron 4 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8224W NP	1	..	..	14.76	15.97	[a] APO-Ondansetron [TX] [a] Ondansetron-DRLA [RZ] [a] Onsetron 4 [ZP]	[a] Ondansetron AN [EA] [a] Ondansetron SZ [HX] [a] Zofran [AS]

▪ ONDANSETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

ondansetron 8 mg/4 mL injection, 4 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8227B NP	1	..	..	11.64	12.85	[a] Ondansetron Alphapharm [AF]	[a] Onsetron [ZP]

ondansetron 4 mg/2 mL injection, 2 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8226Y NP	1	..	..	11.43	12.64	[a] Ondansetron Alphapharm [AF]	[a] Onsetron [ZP]

▪ ONDANSETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

ondansetron 4 mg/5 mL oral liquid, 50 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9441X NP	‡1	..	..	97.94	39.50	Zofran syrup 50 mL [AS]

▪ ONDANSETRON

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

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

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

ONDANSETRON Tablet (orally disintegrating) 8 mg, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5471Y NP	1	..	..	16.84	18.05	[a] Ondansetron AN ODT [EA] [a] Ondansetron ODT GH [GQ]	[a] Ondansetron ODT-DRLA [RZ] [a] Ondansetron SZ ODT [HX]

ondansetron 4 mg wafer, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8410P NP	1	..	[B]2.45	17.21	15.97	[a] Zofran Zydis [AS]

ondansetron 8 mg wafer, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8411Q NP	1	..	[B]2.45	19.29	18.05	[a] Zofran Zydis [AS]

ONDANSETRON Tablet (orally disintegrating) 4 mg, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5470X NP	1	..	..	14.76	15.97	[a] Ondansetron AN ODT [EA] [a] Ondansetron ODT GH [GQ]	[a] Ondansetron ODT-DRLA [RZ] [a] Ondansetron SZ ODT [HX]

▪ ONDANSETRON

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

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

Authority required (STREAMLINED)

5777

Nausea and vomiting

Clinical criteria:

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

ONDANSETRON Tablet (orally disintegrating) 4 mg, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5472B NP	1	1	..	20.26	21.47	[a] Ondansetron AN ODT [EA] [a] Ondansetron ODT GH [GQ] [a] Zilfojim ODT 4 [DO]	[a] Ondansetron ODT-DRLA [RZ] [a] Ondansetron SZ ODT [HX]

ondansetron 4 mg wafer, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8412R NP	1	1	[B]2.45	22.71	21.47	[a] Zofran Zydis [AS]

ondansetron 8 mg wafer, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8413T NP	1	1	[B]2.45	27.93	26.69	[a] Zofran Zydis [AS]

ONDANSETRON Tablet (orally disintegrating) 8 mg, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5473C NP	1	1	..	25.48	26.69	[a] Ondansetron AN ODT [EA] [a] Ondansetron ODT GH [GQ] [a] Zilfojim ODT 8 [DO]	[a] Ondansetron ODT-DRLA [RZ] [a] Ondansetron SZ ODT [HX]

▪ PALONOSETRON

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

Note This drug is not PBS-subsidised for administration with oral 5-HT3 antagonists.

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

palonosetron 250 microgram/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5295Q NP	1	..	..	46.18	39.50	Aloxi [MF]

▪ TROPISETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

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

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

tropisetron 5 mg/5 mL injection, 5 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2746M NP	1	..	..	16.00	17.21	Tropisetron-AFT [AE]

Other antiemetics

▪ APREPITANT

Note Aprepitant is not PBS-subsidised for nausea and vomiting associated with radiotherapy being used to treat malignancy.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4211

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following agents: altretamine; carmustine; cisplatin when a single dose constitutes a cycle of chemotherapy; cyclophosphamide at a dose of 1500 mg per square metre per day or greater; dacarbazine; procarbazine when a single dose constitutes a cycle of chemotherapy; streptozocin.

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

Authority required (STREAMLINED)

4215

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat breast cancer, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**
- Patient must be scheduled to be co-administered cyclophosphamide and an anthracycline.

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

Authority required (STREAMLINED)

6444

Nausea and vomiting

Clinical criteria:

- The condition must be associated with moderately emetogenic cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must have had a prior episode of chemotherapy induced nausea or vomiting, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following intravenous chemotherapy agents: arsenic trioxide; azacitidine; cyclophosphamide at a dose of less than 1500 mg per square metre per day; cytarabine at a dose of greater than 1 g per square metre per day; dactinomycin; daunorubicin; doxorubicin; epirubicin; fotemustine; idarubicin; ifosfamide; irinotecan; melphalan; methotrexate at a dose of 250 mg to 1 g per square metre; raltitrexed.

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

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

Authority required (STREAMLINED)

6370

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes either carboplatin or oxaliplatin.

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

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

aprepitant 165 mg capsule, 1

2518M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	115.56	39.50	Emend [MK]

▪ FOSAPREPITANT

Note This medicine is not PBS-subsidised for nausea and vomiting associated with radiotherapy being used to treat malignancy.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6886

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following agents: altretamine; carmustine; cisplatin when a single dose constitutes a cycle of chemotherapy; cyclophosphamide at a dose

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

No more than 1 vial of fosaprepitant 150 mg injection will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)

6891

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat breast cancer, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**
- Patient must be scheduled to be co-administered cyclophosphamide and an anthracycline.

No more than 1 vial of fosaprepitant 150 mg injection will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)

6887

Nausea and vomiting

Clinical criteria:

- The condition must be associated with moderately emetogenic cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must have had a prior episode of chemotherapy induced nausea or vomiting, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following intravenous chemotherapy agents: arsenic trioxide; azacitidine; cyclophosphamide at a dose of less than 1500 mg per square metre per day; cytarabine at a dose of greater than 1 g per square metre per day; dactinomycin; daunorubicin; doxorubicin; epirubicin; fotemustine; idarubicin; ifosfamide; irinotecan; melphalan; methotrexate at a dose of 250 mg to 1 g per square metre; raltitrexed.

No more than 1 vial of fosaprepitant 150 mg injection will be authorised per cycle of cytotoxic chemotherapy.

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

Authority required (STREAMLINED)

6852

Nausea and vomiting

Clinical criteria:

- The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**
- The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone on day 1 of a chemotherapy cycle, **AND**
- Patient must be scheduled to be administered a chemotherapy regimen that includes either carboplatin or oxaliplatin.

No more than 1 vial of fosaprepitant 150 mg injection will be authorised per cycle of cytotoxic chemotherapy.

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

fosaprepitant 150 mg injection, 1 vial

11107N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	115.56	39.50	Emend IV [MK]

▪ PROCHLORPERAZINE

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

prochlorperazine maleate 5 mg tablet, 25

5205Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.06	13.27	[a] APO-Prochlorperazine [TX] [a] Prochlorperazine AN [EA] [a] Stemzine [AV]	[a] ProCalm [RW] [a] Prochlorperazine GH [GQ]
			[B]3.00	15.06	13.27	[a] Stemetil [SW]	

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

5206B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	20.77	21.98	Stemetil [SW]

▪ PROCHLORPERAZINE

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

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

prochlorperazine maleate 5 mg tablet, 25

2893G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.06	13.27	[a] APO-Prochlorperazine [TX] [a] Prochlorperazine AN [EA]	[a] ProCalm [RW] [a] Prochlorperazine GH [GQ]

					[a] Stemzine [AV]
	[B]3.00	15.06	13.27	[a] Stemetil [SW]	

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

2369Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	20.77	21.98	Stemetil [SW]

▪ PROMETHAZINE

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

3374N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	2	..	..	*38.67	39.50	Hospira Pty Limited [PF]

▪ BILE AND LIVER THERAPY

BILE THERAPY

Bile acid preparations

▪ URSODEOXYCHOLIC ACID

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

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

5757

Primary biliary cirrhosis

ursodeoxycholic acid 500 mg tablet, 100

11180K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	288.57	39.50	Ursofalk [OA]

ursodeoxycholic acid 250 mg capsule, 100

8448P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*307.49	39.50	[a] APO-Ursodeoxycholic acid [TX]	[a] Ursodox GH [GQ]
						[a] Ursofalk [OA]	[a] Ursosan [BZ]

▪ DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Contact laxatives

▪ BISACODYL

Restricted benefit

Constipation

Clinical criteria:

- Patient must be paraplegic or quadriplegic or have severe neurogenic impairment of bowel function.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

bisacodyl 5 mg enteric tablet, 200

1259G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	17.08	18.29	Lax-Tab [AE]

▪ BISACODYL

Restricted benefit

Constipation

Clinical criteria:

- Patient must be paraplegic or quadriplegic or have severe neurogenic impairment of bowel function.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility.

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult.

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Terminal malignant neoplasia

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Anorectal congenital abnormalities

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Megacolon

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

bisacodyl 10 mg suppository, 12

1258F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	4	..	*21.43	22.64	Petrus Bisacodyl Suppositories [PP]

bisacodyl 10 mg suppository, 10

1260H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*23.71	24.92	[a] Petrus Bisacodyl Suppositories [PP]
			[B]1.29	*25.00	24.92	[a] Dulcolax [VZ]

Bulk-forming laxatives

▪ RHAMNUS FRANGULA + STERCULIA

Restricted benefit

Constipation

Clinical criteria:

- Patient must be paraplegic or quadriplegic or have severe neurogenic impairment of bowel function.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be receiving palliative care.

Restricted benefit
Terminal malignant neoplasia
Restricted benefit
Anorectal congenital abnormalities
Restricted benefit
Megacolon

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1104D NP	‡1	1	..	27.57	28.78	Normacol Plus [NE]

Osmotically acting laxatives

▪ MACROGOL-3350

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

Restricted benefit
Constipation
Clinical criteria:
- Patient must have malignant neoplasia.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be paraplegic, quadriplegic or have severe neurogenic impairment of bowel function, **AND**
- The condition must be unresponsive to other oral therapies.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be receiving palliative care.

Restricted benefit
Chronic constipation
Clinical criteria:
- The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

Restricted benefit
Faecal impaction
Clinical criteria:
- The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2373X NP	‡1	5	..	18.66	19.87	[a] Herron ClearLax [ON]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3416T NP	‡1	5	..	18.66	19.87	[a] OsmoLax [KY]

▪ MACROGOL-3350 + SODIUM CHLORIDE + BICARBONATE + POTASSIUM CHLORIDE

Restricted benefit
Constipation
Clinical criteria:
- Patient must have malignant neoplasia.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be paraplegic, quadriplegic or have severe neurogenic impairment of bowel function, **AND**
- The condition must be unresponsive to other oral therapies.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be receiving palliative care.

Restricted benefit
Chronic constipation

Clinical criteria:

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

Restricted benefit

Faecal impaction

Clinical criteria:

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

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8612G NP	‡1	5	..	18.66	19.87	[a] APO-MACROGOL plus ELECTROLYTES [TX] [a] LaxaCon [EA] [a] Macrovic [RF] [a] Movicol [NE]	[a] Chemists' Own Macrogol with Electrolytes [RW] [a] lax-sachets [AE] [a] Molaxole [HM]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10126Y NP	2	5	..	*21.17	22.38	Movicol Liquid [NE]

Enemas

▪ BISACODYL

Restricted benefit

Constipation

Clinical criteria:

- Patient must be paraplegic or quadriplegic or have severe neurogenic impairment of bowel function.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1263L NP	‡1	2	..	38.50	39.50	Bisalax [AS]

▪ SORBITOL + CITRIC ACID + LAURYL SULFOACETATE SODIUM

Restricted benefit

Constipation

Clinical criteria:

- Patient must be paraplegic or quadriplegic or have severe neurogenic impairment of bowel function.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility.

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult.

Restricted benefit
Constipation
Clinical criteria:
- Patient must be receiving palliative care.

Restricted benefit
Terminal malignant neoplasia
Restricted benefit
Anorectal congenital abnormalities
Restricted benefit
Megacolon

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2091C NP	2	2	..	*29.35	30.56	Micolette [AE]

ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS

INTESTINAL ANTIINFECTIVES

Antibiotics

NYSTATIN

nystatin 500 000 units capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1699K NP	1	..	..	20.64	21.85	Nilstat [QA]

nystatin 500 000 units capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3345C DP	1	..	..	20.64	21.85	Nilstat [QA]

nystatin 500 000 units tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1696G NP	1	..	..	20.64	21.85	Nilstat [QA]

nystatin 500 000 units tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3342X DP	1	..	..	20.64	21.85	Nilstat [QA]

RIFAXIMIN

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

Authority required
Prevention of hepatic encephalopathy
Treatment criteria:
- Must be treated by a gastroenterologist or hepatologist or in consultation with a gastroenterologist or hepatologist.

Clinical criteria:
- The treatment must be in combination with lactulose, if lactulose is tolerated, **AND**
- Patient must have had prior episodes of hepatic encephalopathy.

rifaximin 550 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10001J	1	5	..	490.78	39.50	Xifaxan [NE]

VANCOMYCIN

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

Authority required
Antibiotic associated pseudomembranous colitis
Clinical criteria:
- The condition must be due to **Clostridium difficile**, **AND**
- The condition must be unresponsive to metronidazole.

Authority required
Antibiotic associated pseudomembranous colitis
Clinical criteria:
- The condition must be due to **Clostridium difficile**, **AND**

- Patient must have an intolerance to metronidazole.

vancomycin 250 mg capsule, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3114X	2	..	..	*434.95	39.50	Vancocin [AS]

vancomycin 125 mg capsule, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3113W	2	..	..	*219.91	39.50	Vancocin [AS]

ELECTROLYTES WITH CARBOHYDRATES

Oral rehydration salt formulations

▪ SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE MONOHYDRATE + CITRIC ACID

Authority required

Rehydration in intestinal failure

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
11049M	30	..	..	*155.35	39.50	[a] Repalyte New Formulation [SW]	[a] restore O.R.S. [EA]

▪ SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE MONOHYDRATE + CITRIC ACID

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

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3196F NP	‡1	..	..	15.90	17.11	[a] O.R.S. [AS] [a] restore O.R.S. [EA]	[a] Repalyte New Formulation [SW]

ANTIPROPULSIVES

Antipropulsives

▪ DIPHENOXYLATE + ATROPINE SULFATE MONOHYDRATE

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2501P NP	1	..	..	12.87	14.08	[a] Lofenoxal [IA]
			[B]1.51	14.38	14.08	[a] Lomotil [IV]

▪ LOPERAMIDE

Authority required (STREAMLINED)

6364

Diarrhoea

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

loperamide hydrochloride 2 mg capsule, 12

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1571Q NP	1	..	..	12.58	13.79	[a] Gastrex [CR]
			[B]0.65	13.23	13.79	[a] Imodium [JT]

▪ LOPERAMIDE

Authority required

Diarrhoea

loperamide hydrochloride 2 mg capsule, 12

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10889D NP	5	..	..	*18.55	19.76	[a] Gastrex [CR]
			[B]3.25	*21.80	19.76	[a] Imodium [JT]

INTESTINAL ANTIINFLAMMATORY AGENTS

Corticosteroids acting locally

▪ BUDESONIDE

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

budesonide 2 mg/application enema, 2 x 14 applications

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10034D NP	1	3	..	188.64	39.50	Budenofalk [OA]

▪ HYDROCORTISONE ACETATE

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

Restricted benefit
Proctitis
Restricted benefit
Ulcerative colitis

hydrocortisone acetate 10% enema, 21.1 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1502C NP	2	3	..	*40.67	39.50	Colifoam [HM]

▪ PREDNISOLONE SODIUM PHOSPHATE

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

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1920C NP	4	3	..	*198.27	39.50	Predsol [QA]

▪ PREDNISOLONE SODIUM PHOSPHATE

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

Restricted benefit
Proctitis
Restricted benefit
Ulcerative colitis

prednisolone (as sodium phosphate) 5 mg suppository, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2554K NP	3	3	..	*41.86	39.50	Predsol [QA]

Aminosalicylic acid and similar agents

▪ BALSALAZIDE

Note Not for the treatment of Crohn disease
Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4824
Ulcerative colitis
Clinical criteria:
- Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR
- Patient must be intolerant to sulfasalazine.

balsalazide sodium 750 mg capsule, 180

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8845M NP	1	5	..	113.36	39.50	Colazide [PK]

▪ MESALAZINE

Note Not for the treatment of Crohn disease

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4824

Ulcerative colitis

Clinical criteria:

- Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR
- Patient must be intolerant to sulfasalazine.

mesalazine 1.5 g granules, 60 sachets

9206M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	221.60	39.50	Salofalk [OA]

mesalazine 4 g modified release granules, 30 sachets

10254Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	287.85	39.50	Pentasa [FP]

mesalazine 800 mg enteric tablet, 90

11210B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*344.51	39.50	Asacol [EU]

mesalazine 500 mg granules, 100 sachets

8598M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*273.23	39.50	Salofalk [OA]

mesalazine 1.2 g modified release tablet, 60

9353G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*391.35	39.50	Mezavant [ZI]

mesalazine 1 g modified release granules, 100 sachets

8599N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	255.73	39.50	Salofalk [OA]

mesalazine 3 g granules, 30 sachets

10257W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	221.60	39.50	Salofalk [OA]

▪ MESALAZINE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4873

Ulcerative colitis

Clinical criteria:

- Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR
- Patient must be intolerant to sulfasalazine.

Authority required (STREAMLINED)

4896

Crohn disease

Clinical criteria:

- Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR
- Patient must be intolerant to sulfasalazine.

mesalazine 2 g modified release granules, 60 sachets

2287J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	287.85	39.50	Pentasa [FP]

mesalazine 500 mg enteric tablet, 100

8731M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*273.23	39.50	Salofalk [OA]

mesalazine 1 g modified release granules, 120 sachets

2234N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	305.91	39.50	Pentasa [FP]

mesalazine 500 mg modified release tablet, 100

2214M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*273.23	39.50	Pentasa [FP]

mesalazine 250 mg enteric tablet, 100

1611T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	86.24	39.50	Mesasal [AS]

mesalazine 1 g modified release tablet, 60

3413P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*305.91	39.50	Pentasa [FP]

▪ MESALAZINE

Note Not for the treatment of Crohn disease

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

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

Note Continuing Therapy Only:

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

Restricted benefit

Acute episode of mild to moderate ulcerative proctitis

mesalazine 1 g suppository, 30

5461K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	123.34	39.50	Salofalk [OA]

mesalazine 1 g suppository, 30

8752P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	123.34	39.50	Pentasa [FP]

▪ MESALAZINE

Note Not for the treatment of Crohn disease

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

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

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4888

Acute episode of mild to moderate ulcerative colitis

mesalazine 1 g/application enema, 14 applications

8768L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	1	..	*311.39	39.50	Salofalk [OA]

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

8616L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	1	..	*311.39	39.50	Salofalk [OA]

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

8617M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	1	..	*419.19	39.50	Salofalk [OA]

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

8753Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	1	..	*311.39	39.50	Pentasa [FP]

▪ OLSALAZINE

Note Not for the treatment of Crohn disease

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4824

Ulcerative colitis

Clinical criteria:

- Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR
- Patient must be intolerant to sulfasalazine.

olsalazine sodium 250 mg capsule, 100

1728Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.58	39.50	Dipentum [IX]

olsalazine sodium 500 mg tablet, 100

8086N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	94.75	39.50	Dipentum [IX]

▪ SULFASALAZINE

Note Continuing Therapy Only:

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

sulfasalazine 500 mg tablet, 100

2093E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*50.45	39.50	Salazopyrin [PF]

sulfasalazine 500 mg enteric tablet, 100

2096H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*54.43	39.50	[a] Pyralin EN [FZ]
			[B]4.00	*58.43	39.50	[a] Salazopyrin-EN [PF]

▪ SULFASALAZINE

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

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

Restricted benefit

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

sulfasalazine 500 mg tablet, 100

9208P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	11	..	*50.45	39.50	Salazopyrin [PF]

sulfasalazine 500 mg enteric tablet, 100

9209Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	11	..	*54.43	39.50	[a] Pyralin EN [FZ]
			[B]4.00	*58.43	39.50	[a] Salazopyrin-EN [PF]

▪ DIGESTIVES, INCL. ENZYMES

DIGESTIVES, INCL. ENZYMES

Enzyme preparations

▪ PANCREATIC EXTRACT

Note Continuing Therapy Only:

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

pancreatic extract 40 000 units modified release capsule, 100

9412J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	10	..	*206.89	39.50	Creon 40,000 [GO]

pancreatic extract 25 000 units modified release capsule, 100

8021E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	10	..	*133.15	39.50	Creon 25,000 [GO]

pancreatic extract 10 000 units modified release capsule, 100

8020D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	10	..	*164.20	39.50	Creon 10,000 [GO]

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

5453B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	10	..	*127.99	39.50	Creon Micro [GO]

▪ PANCREATIC EXTRACT

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

Restricted benefit
Cystic fibrosis
Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

pancreatic extract 40 000 units modified release capsule, 100

9413K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	21	..	*206.89	39.50	Creon 40,000 [GO]

pancreatic extract 25 000 units modified release capsule, 100

9227P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	21	..	*133.15	39.50	Creon 25,000 [GO]

pancreatic extract 10 000 units modified release capsule, 100

9226N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	21	..	*164.20	39.50	Creon 10,000 [GO]

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

5454C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	21	..	*127.99	39.50	Creon Micro [GO]

▪ PANCRELIPASE

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

pancrelipase 25 000 units capsule, 100

8366H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	10	..	*124.63	39.50	Panzytrat 25000 [TM]

▪ PANCRELIPASE

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

Restricted benefit
Cystic fibrosis
Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

pancrelipase 25 000 units capsule, 100

9229R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	21	..	*124.63	39.50	Panzytrat 25000 [TM]

DRUGS USED IN DIABETES

INSULINS AND ANALOGUES

Insulins and analogues for injection, fast-acting

INSULIN ASPART

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8435Y NP	5	1	..	*240.60	39.50	NovoRapid FlexPen [NF]	NovoRapid Penfill 3 mL [NO]

insulin aspart 100 units/mL injection, 1 x 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8571D NP	5	2	..	*143.15	39.50	NovoRapid [NO]

INSULIN GLULISINE

insulin glulisine 100 units/mL injection, 1 x 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9224L NP	5	2	..	*143.15	39.50	Apidra [SW]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1921D NP	5	1	..	*240.60	39.50	Apidra [AV]	Apidra SoloStar [SW]

INSULIN LISPRO

insulin lispro 100 units/mL injection, 1 x 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8084L NP	5	2	..	*143.15	39.50	Humalog [LY]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8212F NP	5	1	..	*240.60	39.50	Humalog [LY]	Humalog KwikPen [KP]

INSULIN NEUTRAL BOVINE

Authority required

Diabetes mellitus

Clinical criteria:

- Patient must be intolerant to human insulin.

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1713E NP	5	2	..	*394.25	39.50	Hypurin Neutral [AS]

INSULIN NEUTRAL HUMAN

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1762R NP	5	1	..	*201.35	39.50	Actrapid Penfill 3 mL [NO]	Humulin R [LY]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1531N NP	5	2	..	*121.10	39.50	Actrapid [NO]	Humulin R [LY]

Insulins and analogues for injection, intermediate-acting

INSULIN ISOPHANE BOVINE

Authority required

Diabetes mellitus

Clinical criteria:

- Patient must be intolerant to human insulin.

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1711C NP	5	2	..	*394.25	39.50	Hypurin Isophane [AS]

▪ INSULIN ISOPHANE HUMAN

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

1761Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*201.35	39.50	Humulin NPH [LY] Protaphane Penfill 3 mL [NO]	Protaphane InnoLet [NI]

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

1533Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	2	..	*121.10	39.50	Humulin NPH [LY]	Protaphane [NO]

Insulins and analogues for injection, intermediate- or long-acting combined with fast-acting

▪ INSULIN ASPART + INSULIN ASPART PROTAMINE

insulin aspart 30 units/mL + insulin aspart protamine 70 units/mL injection, 5 x 3 mL syringes

8609D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*240.60	39.50	NovoMix 30 FlexPen [NF]	NovoMix 30 Penfill 3 mL [NO]

▪ INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL HUMAN

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

2062M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*201.35	39.50	Mixtard 50/50 Penfill 3 mL [NO]

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

1426C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	2	..	*121.10	39.50	Humulin 30/70 [LY]

insulin isophane human 70 units/mL + insulin neutral human 30 units/mL injection, 5 x 3 mL cartridges

1763T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*201.35	39.50	Humulin 30/70 [LY] Mixtard 30/70 Penfill 3 mL [NO]	Mixtard 30/70 InnoLet [NI]

▪ INSULIN LISPRO + INSULIN LISPRO PROTAMINE

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

8874C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*240.60	39.50	Humalog Mix50 [LY]	Humalog Mix50 KwikPen [KP]

insulin lispro 25 units/mL + insulin lispro protamine 75 units/mL injection, 5 x 3 mL cartridges

8390N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*240.60	39.50	Humalog Mix25 [LY]	Humalog Mix25 KwikPen [KP]

Insulins and analogues for injection, long-acting

▪ INSULIN DETEMIR

Restricted benefit
Type 1 diabetes

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

9040T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*385.65	39.50	Levemir FlexPen [NF]	Levemir Penfill [NO]

▪ INSULIN GLARGINE

insulin glargine 100 units/mL injection, 5 x 3 mL cartridges

9039R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*406.25	39.50	Lantus [SW]	Lantus SoloStar [AV]

BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS

Biguanides

▪ METFORMIN

metformin hydrochloride 1 g modified release tablet, 60

3439B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.40	16.61	[a] APO-Metformin XR 1000 [TX]	[a] Blooms the Chemist Metformin XR 1000 [IB]

						[a] Chem mart Metformin XR 1000 [CH]	[a] Diaformin XR 1000 [AF]
						[a] METEX XR 1000 [RW]	[a] Terry White Chemists Metformin XR 1000 [TW]
			[B]4.95	20.35	16.61	[a] Diabex XR 1000 [AL]	

metformin hydrochloride 500 mg modified release tablet, 120

9435N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.40	16.61	[a] APO-Metformin XR 500 [TX]	[a] Blooms the Chemist Metformin XR 500 [IB]
						[a] Chem mart Metformin XR 500 [CH]	[a] Diaformin XR [AF]
						[a] Metex XR [RW]	[a] Metformin XR 500 APOTEX [GX]
						[a] Terry White Chemists Metformin XR 500 [TW]	
			[B]4.95	20.35	16.61	[a] Diabex XR [AL]	

metformin hydrochloride 1 g tablet, 90

8607B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.78	16.99	[a] APO-Metformin 1000 [TX]	[a] Chem mart Metformin 1000 [CH]
						[a] Diaformin 1000 [AF]	[a] Formet 1000 [RW]
						[a] Glucobete 1000 [DO]	[a] Metformin AN [EA]
						[a] Metformin generichealth 1000 [GQ]	[a] Metformin Ranbaxy 1000 [RA]
						[a] Metformin Sandoz [SZ]	[a] Pharmacor Metformin 1000 [CR]
						[a] Terry White Chemists Metformin 1000 [TW]	
			[B]4.95	20.73	16.99	[a] Diabex 1000 [AL]	

metformin hydrochloride 500 mg tablet, 100

2430X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.78	14.99	[a] APO-Metformin 500 [TX]	[a] Chem mart Metformin [CH]
						[a] Diaformin [AF]	[a] FORMET 500 [RF]
						[a] Formet Aspen 500 [RW]	[a] Glucobete 500 [DO]
						[a] Metformin 500 [CR]	[a] Metformin AN [EA]
						[a] Metformin generichealth [GQ]	[a] Metformin Sandoz [SZ]
						[a] Terry White Chemists Metformin [TW]	
			[B]4.95	18.73	14.99	[a] Diabex [AL]	

metformin hydrochloride 850 mg tablet, 60

1801T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.78	14.99	[a] APO-Metformin 850 [TX]	[a] Chem mart Metformin [CH]
						[a] Diaformin 850 [AF]	[a] FORMET 850 [RF]
						[a] Formet Aspen 850 [RW]	[a] Glucobete 850 [DO]
						[a] Metformin 850 [CR]	[a] Metformin AN [EA]
						[a] Metformin Sandoz [SZ]	[a] Terry White Chemists Metformin [TW]
			[B]4.95	18.73	14.99	[a] Diabex 850 [AL]	

Sulfonylureas

▪ GLIBENCLAMIDE

Caution Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glibenclamide 5 mg tablet, 100

2939Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.41	16.62	Daonil [SW]

▪ GLICLAZIDE

Caution Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

gliclazide 30 mg modified release tablet, 100

8535F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.12	18.33	[a] APO-Gliclazide MR [TX]	[a] Chem mart Gliclazide MR [CH]
						[a] Glyade MR [AF]	[a] Terry White Chemists Gliclazide MR [TW]

gliclazide 60 mg modified release tablet, 60

9302N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.33	19.54	[a] ARDIX GLICLAZIDE 60mg MR [RX]
			[B]6.62	24.95	19.54	[a] Diamicron 60mg MR [SE]

gliclazide 80 mg tablet, 100

2449X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.95	18.16	[a] Chem mart Gliclazide [CH] [a] Glyade [AF] [a] Terry White Chemists Gliclazide [TW]	[a] GenRx Gliclazide [GX] [a] Nidem [RW]

▪ GLIMEPIRIDE

Caution Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glimepiride 3 mg tablet, 30

8533D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.44	14.65	[a] APO-Glimepiride [TX] [a] Diapride 3 [RW] [a] Glimepiride AN [EA]	[a] Aylide 3 [AF] [a] Dimirel [AV] [a] Glimepiride Sandoz [SZ]
			[B]2.19	15.63	14.65	[a] Amaryl [SW]	

glimepiride 1 mg tablet, 30

8450R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.06	13.27	[a] APO-Glimepiride [TX] [a] Diapride 1 [RW] [a] Glimepiride AN [EA]	[a] Aylide 1 [AF] [a] Dimirel [AV] [a] Glimepiride Sandoz [SZ]
			[B]2.23	14.29	13.27	[a] Amaryl [SW]	

glimepiride 2 mg tablet, 30

8451T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.94	14.15	[a] APO-Glimepiride [TX] [a] Diapride 2 [RW] [a] Glimepiride AN [EA]	[a] Aylide 2 [AF] [a] Dimirel [AV] [a] Glimepiride Sandoz [SZ]
			[B]2.18	15.12	14.15	[a] Amaryl [SW]	

glimepiride 4 mg tablet, 30

8452W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.99	15.20	[a] APO-Glimepiride [TX] [a] Diapride 4 [RW] [a] Glimepiride AN [EA]	[a] Aylide 4 [AF] [a] Dimirel [AV] [a] Glimepiride Sandoz [SZ]
			[B]2.19	16.18	15.20	[a] Amaryl [SW]	

▪ GLIPIZIDE

Caution Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glipizide 5 mg tablet, 100

2440K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.91	19.12	[a] Melizide [AF]
			[B]8.50	26.41	19.12	[a] Minidiab [PF]

Combinations of oral blood glucose lowering drugs

▪ ALOGLIPTIN + METFORMIN

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

Authority required (STREAMLINED)

4423

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

Authority required (STREAMLINED)

4427

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

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

alogliptin 12.5 mg + metformin hydrochloride 850 mg tablet, 56

10032B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.27	39.50	Nesina Met 12.5/850 [TK]

alogliptin 12.5 mg + metformin hydrochloride 500 mg tablet, 56

10033C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	60.27	39.50	Nesina Met 12.5/500 [TK]

alogliptin 12.5 mg + metformin hydrochloride 1 g tablet, 56

10035E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.68	39.50	Nesina Met 12.5/1000 [TK]

▪ DAPAGLIFLOZIN + METFORMIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

5631

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Authority required (STREAMLINED)

5739

Diabetes mellitus type 2

Treatment Phase: Continuing treatment

Clinical criteria:

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Authority required (STREAMLINED)

5798

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

5657

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

Note This fixed dose combination is not PBS-subsidised as initial therapy or for use in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

dapagliflozin 5 mg + metformin hydrochloride 1 g modified release tablet, 56

10510E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.18	39.50	Xigduo XR 5/1000 [AP]

dapagliflozin 10 mg + metformin hydrochloride 500 mg modified release tablet, 28

10516L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.02	39.50	Xigduo XR 10/500 [AP]

dapagliflozin 10 mg + metformin hydrochloride 1 g modified release tablet, 28

10515K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.78	39.50	Xigduo XR 10/1000 [AP]

▪ EMPAGLIFLOZIN + METFORMIN

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Authority required (STREAMLINED)

5953

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

empagliflozin 12.5 mg + metformin hydrochloride 1 g tablet, 60

10640B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	64.76	39.50	Jardiamet 12.5 mg/1000 mg [BY]

empagliflozin 5 mg + metformin hydrochloride 1 g tablet, 60

10649L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	64.76	39.50	Jardiamet 5 mg/1000 mg [BY]

empagliflozin 5 mg + metformin hydrochloride 500 mg tablet, 60

10650M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	63.25	39.50	Jardiamet 5 mg/500 mg [BY]

empagliflozin 12.5 mg + metformin hydrochloride 500 mg tablet, 60

10639Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	63.25	39.50	Jardiamet 12.5 mg/500 mg [BY]

▪ EMPAGLIFLOZIN + METFORMIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

5966

Diabetes mellitus type 2

Treatment Phase: Continuing treatment

Clinical criteria:

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Authority required (STREAMLINED)

5798

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note This fixed dose combination is not PBS-subsidised for use as initial therapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

5657

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

Note This fixed dose combination is not PBS-subsidised as initial therapy or for use in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

empagliflozin 12.5 mg + metformin hydrochloride 1 g tablet, 60

10677Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	64.76	39.50	Jardiamet 12.5 mg/1000 mg [BY]

empagliflozin 5 mg + metformin hydrochloride 1 g tablet, 60

10627H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	64.76	39.50	Jardiamet 5 mg/1000 mg [BY]

empagliflozin 5 mg + metformin hydrochloride 500 mg tablet, 60

10626G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	63.25	39.50	Jardiamet 5 mg/500 mg [BY]

empagliflozin 12.5 mg + metformin hydrochloride 500 mg tablet, 60

10633P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	63.25	39.50	Jardiamet 12.5 mg/500 mg [BY]

▪ LINAGLIPTIN + METFORMIN

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

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6333

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6336

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

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

Authority required (STREAMLINED)

6344

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

6443

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

linagliptin 2.5 mg + metformin hydrochloride 1 g tablet, 60

10044P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	62.74	39.50	Trajentamet [BY]

linagliptin 2.5 mg + metformin hydrochloride 850 mg tablet, 60

10045Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	62.30	39.50	Trajentamet [BY]

linagliptin 2.5 mg + metformin hydrochloride 500 mg tablet, 60

10038H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.23	39.50	Trajentamet [BY]

▪ METFORMIN + GLIBENCLAMIDE

Caution Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

metformin hydrochloride 500 mg + glibenclamide 5 mg tablet, 90

8811R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.42	19.63	Glucovance 500mg/5mg [AL]

metformin hydrochloride 250 mg + glibenclamide 1.25 mg tablet, 90

8838E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.72	17.93	Glucovance 250mg/1.25mg [AL]

metformin hydrochloride 500 mg + glibenclamide 2.5 mg tablet, 90

8810Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.43	18.64	Glucovance 500mg/2.5mg [AL]

▪ ROSIGLITAZONE + METFORMIN

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

Authority required

Diabetes mellitus type 2

Clinical criteria:

- Patient must have a contraindication to a sulfonylurea; OR
- Patient must not have tolerated a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with metformin.

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

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

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

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

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

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

rosiglitazone 2 mg + metformin hydrochloride 1 g tablet, 56

9060W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.27	39.50	Avandamet [GK]

rosiglitazone 2 mg + metformin hydrochloride 500 mg tablet, 56

9059T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.86	39.50	Avandamet [GK]

rosiglitazone 4 mg + metformin hydrochloride 1 g tablet, 56

9062Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	86.71	39.50	Avandamet [GK]

rosiglitazone 4 mg + metformin hydrochloride 500 mg tablet, 56

9061X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	85.30	39.50	Avandamet [GK]

▪ SAXAGLIPTIN + METFORMIN

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

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

Authority required (STREAMLINED)

6333

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6335

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

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

Authority required (STREAMLINED)

6344

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

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

10055F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	57.13	39.50	Kombiglyze XR 5/500 [AP]

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

10048W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.29	39.50	Kombiglyze XR 2.5/1000 [AP]

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

10051B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	57.88	39.50	Kombiglyze XR 5/1000 [AP]

▪ SITAGLIPTIN + METFORMIN

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

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

Authority required (STREAMLINED)

6333

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6334

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

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

Authority required (STREAMLINED)

6344

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

6443

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

10089B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	57.88	39.50	Janumet XR [MK]

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

10090C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.29	39.50	Janumet XR [MK]

sitagliptin 50 mg + metformin hydrochloride 500 mg tablet, 56

9449H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	57.88	39.50	Janumet [MK]

sitagliptin 50 mg + metformin hydrochloride 1 g tablet, 56

9451K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.29	39.50	Janumet [MK]

sitagliptin 50 mg + metformin hydrochloride 850 mg tablet, 56

9450J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.88	39.50	Janumet [MK]

▪ VILDAGLIPTIN + METFORMIN

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

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6333

Diabetes mellitus type 2

Clinical criteria:

- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6357

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

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

Authority required (STREAMLINED)

6344

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with optimal doses of dual oral therapy; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with optimal doses of dual oral therapy.

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

vildagliptin 50 mg + metformin hydrochloride 500 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5474D NP	1	5	..	58.43	39.50	Galvumet 50/500 [NV]

vildagliptin 50 mg + metformin hydrochloride 850 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5475E NP	1	5	..	59.51	39.50	Galvumet 50/850 [NV]

vildagliptin 50 mg + metformin hydrochloride 1 g tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5476F NP	1	5	..	59.95	39.50	Galvumet 50/1000 [NV]

Alpha glucosidase inhibitors

▪ ACARBOSE

acarbose 50 mg tablet, 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8188Y NP	1	5	..	30.59	31.80	[a] Acarbose Mylan [AF]	[a] Glucobay 50 [BN]

acarbose 100 mg tablet, 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8189B NP	1	5	..	38.71	39.50	[a] Acarbose Mylan [AF]	[a] Glucobay 100 [BN]

Thiazolidinediones

▪ PIOGLITAZONE

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

Authority required (STREAMLINED)

4363

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR
- Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

Authority required (STREAMLINED)

4388

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

Authority required (STREAMLINED)

4364

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

pioglitazone 30 mg tablet, 28

8695P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.04	24.25	[a] Acpio 30 [RF] [a] Actos [TK] [a] Chem mart Pioglitazone [CH] [a] Pioglitazone Sandoz [SZ] [a] Terry White Chemists Pioglitazone [TW]	[a] Actaze [RW] [a] APOTEX-Pioglitazone [TX] [a] Pioglitazone AN [EA] [a] Prioten 30 [DO] [a] Vexazone [AF]

pioglitazone 45 mg tablet, 28

8696Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.62	27.83	[a] Acpio 45 [RF] [a] Actos [TK] [a] Chem mart Pioglitazone [CH] [a] Pioglitazone Sandoz [SZ] [a] Prioten 45 [DO] [a] Vexazone [AF]	[a] Actaze [RW] [a] APOTEX-Pioglitazone [TX] [a] Pioglitazone AN [EA] [a] Pizaccord [RA] [a] Terry White Chemists Pioglitazone [TW]

pioglitazone 15 mg tablet, 28

8694N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.85	20.06	[a] Acpio 15 [RF] [a] Actos [TK] [a] Chem mart Pioglitazone [CH] [a] Pioglitazone Sandoz [SZ] [a] Prioten 15 [DO] [a] Vexazone [AF]	[a] Actaze [RW] [a] APOTEX-Pioglitazone [TX] [a] Pioglitazone AN [EA] [a] Pizaccord [RA] [a] Terry White Chemists Pioglitazone [TW]

Dipeptidyl peptidase 4 (DPP-4) inhibitors

▪ ALOGLIPTIN

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

Authority required (STREAMLINED)

4349

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

alogliptin 25 mg tablet, 28

2986E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.76	39.50	Nesina [TK]

alogliptin 12.5 mg tablet, 28

2933J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.76	39.50	Nesina [TK]

alogliptin 6.25 mg tablet, 28

2944Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.76	39.50	Nesina [TK]

▪ LINAGLIPTIN

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

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

Authority required (STREAMLINED)

6346

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6363

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

6376

Diabetes mellitus type 2

Clinical criteria:

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

peptide-1 or an SGLT2 inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated.

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

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

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

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

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

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

linagliptin 5 mg tablet, 30

3387G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.61	39.50	Trajenta [BY]

▪ SAXAGLIPTIN

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6346

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6363

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

saxagliptin 2.5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10128C NP	1	5	..	56.38	39.50	Onglyza [AP]

saxagliptin 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8983T NP	1	5	..	56.38	39.50	Onglyza [AP]

▪ SITAGLIPTIN

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

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

Authority required (STREAMLINED)

6346

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6363

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

6376

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

sitagliptin 25 mg tablet, 28

9180E NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	56.38	39.50	Januvia [MK]

sitagliptin 100 mg tablet, 28

9182G NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	56.38	39.50	Januvia [MK]

sitagliptin 50 mg tablet, 28

9181F NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	56.38	39.50	Januvia [MK]

▪ VILDAGLIPTIN

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6346

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

6363

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

vildagliptin 50 mg tablet, 60

3415R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.61	39.50	Galvus [NV]

Glucagon-like peptide-1 (GLP-1) analogues

▪ EXENATIDE

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), an insulin or an SGLT2 inhibitor.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6519

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR
- Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

Authority required (STREAMLINED)

6505

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

exenatide 2 mg/dose injection: modified release, 4 injection devices

10888C

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	130.91	39.50	Bydureon [AP]

▪ EXENATIDE

Note This drug is not PBS-subsidised for use as monotherapy or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone) or an SGLT2 inhibitor.

Authority required (STREAMLINED)

5500

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR
- Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

Authority required (STREAMLINED)

5478

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

Authority required (STREAMLINED)

5469

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with insulin, **AND**
- The treatment must be in combination with metformin unless contraindicated or not tolerated, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated.

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

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

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

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

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

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

exenatide 5 microgram/dose injection, 60 doses

3423E

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	66.00	39.50	Byetta 5 microgram [AP]

exenatide 10 microgram/dose injection, 60 doses

3424F

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	89.54	39.50	Byetta 10 microgram [AP]

Sodium-glucose co-transporter 2 (SGLT2) inhibitors

▪ DAPAGLIFLOZIN

Note Continuing Therapy Only:

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

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

Authority required (STREAMLINED)

4983

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

4991

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

Authority required (STREAMLINED)

5629

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

dapagliflozin 10 mg tablet, 28

10011X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.27	39.50	Forxiga [AP]

▪ EMPAGLIFLOZIN

Note Continuing Therapy Only:

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

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

Authority required (STREAMLINED)

5629

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

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

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

Note PBS subsidised dual oral therapy does not include concomitant use of a combination of: a gliptin, a glitazone or an SGLT2 inhibitor.

Authority required (STREAMLINED)

4983

Diabetes mellitus type 2

Clinical criteria:

- The treatment must be in combination with metformin; OR
- The treatment must be in combination with a sulfonylurea, **AND**
- Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR
- Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

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

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

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

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

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

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

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

Authority required (STREAMLINED)

4991

Diabetes mellitus type 2

Clinical criteria:

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

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

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

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

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

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

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

empagliflozin 10 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10206E NP	1	5	..	61.64	39.50	Jardiance [BY]

empagliflozin 25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10202Y NP	1	5	..	61.64	39.50	Jardiance [BY]

▪ VITAMINS

VITAMIN A AND D, INCL. COMBINATIONS OF THE TWO

Vitamin D and analogues

▪ CALCITRIOL

Authority required (STREAMLINED)

5401

Hypocalcaemia

Clinical criteria:

- The condition must be due to renal disease.

Authority required (STREAMLINED)

5255

Hypoparathyroidism

Authority required (STREAMLINED)

5089

Hypophosphataemic rickets

Authority required (STREAMLINED)

5114

Vitamin D-resistant rickets

Authority required (STREAMLINED)

5402

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated. A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

calcitriol 0.25 microgram capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2502Q NP	1	3	..	27.21	28.42	[a] APO-Calcitriol [TX] [a] Calcitriol AN [EA] [a] Sical [AF]	[a] Calciprox [ER] [a] Kosteo [RW]
			[B]2.29	29.50	28.42	[a] Rocaltrol [RO]	

VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12

Vitamin B1, plain

▪ THIAMINE

Authority required (STREAMLINED)

5139

Thiamine deficiency

Clinical criteria:

- The treatment must be for prophylaxis.

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

thiamine hydrochloride 100 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1070H NP	1	2	..	14.98	16.19	Betavit [PP]

▪ MINERAL SUPPLEMENTS

CALCIUM

Calcium

▪ CALCIUM

Authority required (STREAMLINED)

4586

Hyperphosphataemia

Clinical criteria:

- The condition must be associated with chronic renal failure.

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3116B NP	4	1	..	*29.67	30.88	Cal-500 [PP]

CALCIUM Tablet 600 mg (as carbonate), 240

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3117C NP	1	1	..	24.12	25.33	Calci-Tab 600 [AE]

POTASSIUM

Potassium

▪ POTASSIUM CHLORIDE

Note For item codes 2642C and 1841X, pharmaceutical benefits that have the form tablet 600 mg (sustained release) are equivalent for the purposes of substitution.

potassium chloride 600 mg (potassium 8 mmol) modified release tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2642C NP	2	1	..	*19.27	20.48	[a] Duro-K [NM]
			[B]3.00	*22.27	20.48	[a] Slow-K [NV]

potassium chloride 600 mg (potassium 8 mmol) modified release tablet, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1841X NP	1	1	..	19.26	20.47	[a] Span-K [AS]

▪ POTASSIUM CHLORIDE + POTASSIUM BICARBONATE + POTASSIUM CARBONATE

potassium chloride 595 mg + potassium bicarbonate 384 mg + potassium carbonate 152 mg effervescent tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3012M NP	1	1	..	20.77	21.98	Chlorvescent [AS]

OTHER MINERAL SUPPLEMENTS

Magnesium

▪ MAGNESIUM ASPARTATE DIHYDRATE

Authority required (STREAMLINED)

5506

Hypomagnesaemia

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Authority required (STREAMLINED)

5466

Chronic renal disease

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5146W NP	1	5	..	17.11	18.32	MagMin (PBS) [BB]	Mag-Sup [PP]

▪ ANABOLIC AGENTS FOR SYSTEMIC USE

ANABOLIC STEROIDS

Estren derivatives

▪ NANDROLONE DECANOATE

Note Monotherapy for the treatment of osteoporosis does not exclude calcium supplementation.

Authority required

Osteoporosis

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The treatment must be where other treatment has failed and where specialist advice confirms that this is the only suitable treatment option for the patient.

Specialist advice need only be obtained for the first authority approval.

Authority required

Osteoporosis

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The treatment must be where other treatment is not tolerated and where specialist advice confirms that this is the only suitable treatment option for the patient.

Specialist advice need only be obtained for the first authority approval.

Authority required

Osteoporosis

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The treatment must be where other treatment is contraindicated and where specialist advice confirms that this is the only suitable treatment option for the patient.

Specialist advice need only be obtained for the first authority approval.

Authority required

Patients receiving this drug as a pharmaceutical benefit prior to 1 February 2004

Authority required

Patients on long-term treatment with corticosteroids

nandrolone decanoate 50 mg/mL injection, 1 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1671Y	1	7	..	23.29	24.50	Deca-Durabolin [AS]

▪ OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS

OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS

Amino acids and derivatives

▪ BETAINE

Authority required

Homocystinuria

Clinical criteria:

- The treatment must be as adjunctive therapy to current standard care, **AND**
- The condition must be treated by or in consultation with a metabolic physician.

The name of the specialist must be included in the authority application.

betaine 1 g/g powder for oral liquid, 180 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10119N	‡1	5	..	565.87	39.50	Cystadane [EU]

Various alimentary tract and metabolism products

▪ SAPROPTERIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Hyperphenylalaninaemia

Treatment Phase: Continuing

Clinical criteria:

- Patient must have hyperphenylalaninaemia (HPA) due to tetrahydrobiopterin (BH4) deficiency, **AND**
- Patient must have previously been issued with an authority prescription for this drug; OR
- Patient must have accessed non-PBS-subsidised treatment prior to 1 May 2014.

Patient must have documented tetrahydrobiopterin (BH4) deficiency using tests for BH4 loading and/or urine pterin metabolites, blood spot dihydropteridine reductase (DHPR) and have cerebrospinal fluid neurotransmitter metabolites measured.

The authority application must be made in writing.

saropterin dihydrochloride 100 mg soluble tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10087X	6	5	..	*5309.53	39.50	Kuvan [IO]

▪ SAPROPTERIN

Note Patients will be eligible for a maximum of one script as initial therapy to enable their response to treatment with sapropterin to be assessed.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Hyperphenylalaninaemia

Treatment Phase: Initial

Clinical criteria:

- Patient must have hyperphenylalaninaemia (HPA) due to tetrahydrobiopterin (BH4) deficiency.

Patient must have documented tetrahydrobiopterin (BH4) deficiency using tests for BH4 loading and/or urine pterin metabolites, blood spot dihydropteridine reductase (DHPR) and have cerebrospinal fluid neurotransmitter metabolites measured.

The authority application must be made in writing.

saropterin dihydrochloride 100 mg soluble tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10086W	6	..	..	*5309.53	39.50	Kuvan [IO]

▪ BLOOD AND BLOOD FORMING ORGANS

▪ ANTITHROMBOTIC AGENTS

ANTITHROMBOTIC AGENTS

Vitamin K antagonists

▪ WARFARIN

Caution The listed brands have NOT been shown to be bioequivalent and should not be interchanged.

warfarin sodium 1 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2843P NP	1	2	..	16.05	17.26	Coumadin [QA]	Marevan [FM]

warfarin sodium 5 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2211J NP	1	2	..	17.38	18.59	Coumadin [QA]	Marevan [FM]

warfarin sodium 2 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2209G NP	1	2	..	16.33	17.54	Coumadin [QA]

warfarin sodium 3 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2844Q NP	1	2	..	16.27	17.48	Marevan [FM]

Heparin group

▪ DALTEPARIN SODIUM

dalteparin sodium 12 500 anti-Xa units/0.5 mL injection, 10 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5445N NP	1	1	..	114.10	39.50	Fragmin [PF]

dalteparin sodium 10 000 anti-Xa units/mL injection, 10 x 1 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8269F NP	1	1	..	84.13	39.50	Fragmin [PF]

dalteparin sodium 5000 anti-Xa units/0.2 mL injection, 10 x 0.2 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2816F NP	2	..	..	*99.55	39.50	Fragmin [PF]

dalteparin sodium 7500 anti-Xa units/0.75 mL injection, 10 x 0.75 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8271H NP	1	1	..	64.60	39.50	Fragmin [PF]

dalteparin sodium 2500 anti-Xa units/0.2 mL injection, 10 x 0.2 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8603T NP	2	..	..	*95.99	39.50	Fragmin [PF]

▪ DALTEPARIN SODIUM

Restricted benefit

Haemodialysis

dalteparin sodium 12 500 anti-Xa units/0.5 mL injection, 10 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1296F NP	2	3	..	*218.03	39.50	Fragmin [PF]

dalteparin sodium 10 000 anti-Xa units/mL injection, 10 x 1 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1229Q NP	2	3	..	*157.17	39.50	Fragmin [PF]

dalteparin sodium 5000 anti-Xa units/0.2 mL injection, 10 x 0.2 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8642W NP	2	3	..	*99.55	39.50	Fragmin [PF]

dalteparin sodium 7500 anti-Xa units/0.75 mL injection, 10 x 0.75 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8643X NP	2	3	..	*118.11	39.50	Fragmin [PF]

dalteparin sodium 2500 anti-Xa units/0.2 mL injection, 10 x 0.2 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8641T NP	2	3	..	*95.99	39.50	Fragmin [PF]

▪ DALTEPARIN SODIUM

Note No applications for increased maximum quantities will be authorised.

Restricted benefit

Symptomatic venous thromboembolism

Treatment Phase: Management

Clinical criteria:

- Patient must have a solid tumour(s).

dalteparin sodium 12 500 anti-Xa units/0.5 mL injection, 10 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8958L NP	3	5	..	*324.64	39.50	Fragmin [PF]

DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 15,000 units (anti-Xa) in 0.6 mL single dose pre-filled syringe, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8959M NP	3	5	..	*388.57	39.50	Fragmin [PF]

DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 18,000 units (anti-Xa) in 0.72 mL single dose pre-filled syringe, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8960N NP	3	5	..	*465.34	39.50	Fragmin [PF]

dalteparin sodium 10 000 anti-Xa units/mL injection, 10 x 1 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8957K NP	3	5	..	*231.58	39.50	Fragmin [PF]

dalteparin sodium 7500 anti-Xa units/0.75 mL injection, 10 x 0.75 mL syringes

8956J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*171.61	39.50	Fragmin [PF]

▪ ENOXAPARIN SODIUM

enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes

8263X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	83.88	39.50	Clexane [SW]

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes

8510X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*99.55	39.50	Clexane [SW]

enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes

8558K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*95.99	39.50	Clexane [SW]

enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes

8264Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	99.75	39.50	Clexane [SW]

enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes

8262W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	74.35	39.50	Clexane [SW]

▪ ENOXAPARIN SODIUM

Restricted benefit

Haemodialysis

enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes

5434B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*156.67	39.50	Clexane [SW]

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes

8639Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*99.55	39.50	Clexane [SW]

enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes

8716R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*95.99	39.50	Clexane [SW]

enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes

5435C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*188.41	39.50	Clexane [SW]

enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes

8640R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*137.61	39.50	Clexane [SW]

▪ HEPARIN SODIUM

heparin sodium 5000 units/0.2 mL injection, 5 x 0.2 mL ampoules

1466E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	23.76	24.97	Hospira Pty Limited [PF]

heparin sodium 35 000 units/35 mL injection, 35 mL vial

1076P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	12	5	..	*354.67	39.50	Hospira Pty Limited [PF]

heparin sodium 5000 units/5 mL injection, 50 x 5 mL ampoules

1463B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	72.69	39.50	Pfizer Australia Pty Ltd [PF]

▪ NADROPARIN

nadroparin calcium 7600 anti-Xa international units/0.8 mL injection, 2 x 0.8 mL syringes

10734Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*82.60	39.50	Fraxiparine [AS]

nadroparin calcium 5700 anti-Xa international units/0.6 mL injection, 2 x 0.6 mL syringes

10716B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*118.35	39.50	Fraxiparine [AS]

nadroparin calcium 3800 anti-Xa international units/0.4 mL injection, 2 x 0.4 mL syringes

10685J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*82.55	39.50	Fraxiparine [AS]

nadroparin calcium 1900 anti-Xa international units/0.2 mL injection, 2 x 0.2 mL syringes

10735B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*46.85	39.50	Fraxiparine [AS]

nadroparin calcium 2850 anti-Xa international units/0.3 mL injection, 2 x 0.3 mL syringes

10686K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*64.75	39.50	Fraxiparine [AS]

nadroparin calcium 19 000 anti-Xa international units/mL injection, 2 x 1 mL syringes

10707M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*189.85	39.50	Fraxiparine Forte [AS]

nadroparin calcium 9500 anti-Xa international units/mL injection, 2 x 1 mL syringes

10702G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*100.50	39.50	Fraxiparine [AS]

nadroparin calcium 11 400 anti-Xa international units/0.6 mL injection, 2 x 0.6 mL syringes

10706L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*118.35	39.50	Fraxiparine Forte [AS]

nadroparin calcium 15 200 anti-Xa international units/0.8 mL injection, 2 x 0.8 mL syringes

10725L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	1	..	*154.10	39.50	Fraxiparine Forte [AS]

▪ NADROPARIN

Restricted benefit
Haemodialysis

nadroparin calcium 7600 anti-Xa international units/0.8 mL injection, 2 x 0.8 mL syringes

10740G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*154.05	39.50	Fraxiparine [AS]

nadroparin calcium 5700 anti-Xa international units/0.6 mL injection, 2 x 0.6 mL syringes

10718D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*118.35	39.50	Fraxiparine [AS]

nadroparin calcium 3800 anti-Xa international units/0.4 mL injection, 2 x 0.4 mL syringes

10717C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*82.55	39.50	Fraxiparine [AS]

nadroparin calcium 1900 anti-Xa international units/0.2 mL injection, 2 x 0.2 mL syringes

10687L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*46.85	39.50	Fraxiparine [AS]

nadroparin calcium 2850 anti-Xa international units/0.3 mL injection, 2 x 0.3 mL syringes

10701F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*64.75	39.50	Fraxiparine [AS]

nadroparin calcium 9500 anti-Xa international units/mL injection, 2 x 1 mL syringes

10733X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	3	..	*189.85	39.50	Fraxiparine [AS]

Platelet aggregation inhibitors excl. heparin

▪ ABCIXIMAB

Authority required (STREAMLINED)

4942

Coronary artery disease

Treatment criteria:

- Patient must be undergoing percutaneous coronary balloon angioplasty.

Authority required (STREAMLINED)

4943

Coronary artery disease

Treatment criteria:

- Patient must be undergoing percutaneous coronary atherectomy.

Authority required (STREAMLINED)

4915

Coronary artery disease

Treatment criteria:

- Patient must be undergoing percutaneous coronary stent placement.

abciximab 10 mg/5 mL injection, 5 mL vial

8048N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*1376.14	39.50	ReoPro [JC]

▪ ASPIRIN

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

aspirin 300 mg effervescent tablet, 96

1010E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.61	13.82	Solprin [RC]

▪ ASPIRIN

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

aspirin 100 mg tablet, 112

8202Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.93	14.14	Spren 100 [OW]

▪ CLOPIDOGREL

Note Not for prophylaxis of deep vein thrombosis or peripheral arterial disease.

Note Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

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

Authority required (STREAMLINED)

4166

Acute coronary syndrome (myocardial infarction or unstable angina)

Clinical criteria:

- The treatment must be in combination with aspirin.

Authority required (STREAMLINED)

4165

Cardiac stent insertion

Clinical criteria:

- The treatment must be in combination with aspirin, **AND**
- The treatment must follow insertion of a cardiac stent.

clopidogrel 75 mg tablet, 28

2275R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.18	16.39	[a] Clopidogrel-GA [EA] [a] Plidogrel [RF]	[a] Clovix 75 [RW]

clopidogrel 75 mg tablet, 28

9317J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.18	16.39	[a] APO-Clopidogrel [TX]	[a] Blooms the Chemist Clopidogrel [IB]
						[a] Chem mart Clopidogrel [CH]	[a] Clopidogrel AN [EA]
						[a] Clopidogrel Winthrop [WA]	[a] Iscover [AV]
						[a] Piax [AF]	[a] Plavix [SW]
						[a] Terry White Chemists Clopidogrel [TW]	

▪ CLOPIDOGREL

Note Not for prophylaxis of deep vein thrombosis or peripheral arterial disease.

Note Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg, clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

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

Authority required (STREAMLINED)

5517

Prevention of recurrence of myocardial infarction or unstable angina

Clinical criteria:

- Patient must have a history of symptomatic cardiac ischaemic events while on therapy with low-dose aspirin.

Authority required (STREAMLINED)

5524

Prevention of recurrence of myocardial infarction or unstable angina

Clinical criteria:

- Patient must be in one whom low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding.

Authority required (STREAMLINED)

5525

Prevention of recurrence of myocardial infarction or unstable angina

Clinical criteria:

- Patient must have a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or non-steroidal anti-inflammatory drugs (NSAIDs).

Authority required (STREAMLINED)

5459

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- Patient must have a history of symptomatic cerebrovascular ischaemic episodes while on therapy with low-dose aspirin.

Authority required (STREAMLINED)

5436

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- Patient must be in one whom low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding.

Authority required (STREAMLINED)

5508

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- Patient must have a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or non-steroidal anti-inflammatory drugs (NSAIDs).

clopidogrel 75 mg tablet, 28

5436D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.18	16.39	[a] Clopidogrel-DRLA [RZ]

clopidogrel 75 mg tablet, 28

8358X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.18	16.39	[a] APO-Clopidogrel [TX]	[a] Blooms the Chemist Clopidogrel [IB]
						[a] Chem mart Clopidogrel [CH]	[a] Clopidogrel AN [EA]
						[a] Clopidogrel RBX [RA]	[a] Clopidogrel Sandoz [SZ]
						[a] Clopidogrel Winthrop [WA]	[a] Iscover [AV]
						[a] Piax [AF]	[a] Plavicor 75 [CR]
						[a] Plavix [SW]	[a] Terry White Chemists Clopidogrel [TW]

clopidogrel 75 mg tablet, 28

9354H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.18	16.39	[a] Clopidogrel-GA [EA] [a] Clovix 75 [RW]	[a] Clopidogrel GH [GQ] [a] Plidogrel [RF]

▪ CLOPIDOGREL + ASPIRIN

Note Not for prophylaxis of deep vein thrombosis or peripheral arterial disease.

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

Authority required (STREAMLINED)

5488

Acute coronary syndrome (myocardial infarction or unstable angina)

Authority required (STREAMLINED)

5443

Cardiac stent insertion

Clinical criteria:

- The treatment must follow insertion of a cardiac stent.

Authority required (STREAMLINED)

5517

Prevention of recurrence of myocardial infarction or unstable angina

Clinical criteria:

- Patient must have a history of symptomatic cardiac ischaemic events while on therapy with low-dose aspirin.

Note Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg, clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

clopidogrel 75 mg + aspirin 100 mg tablet, 30

9296G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.47	16.68	[a] APO-Clopidogrel/Aspirin 75/100 [TX] [a] Clopidogrel/Aspirin Actavis 75/100 [EA] [a] Clopidogrel Winthrop plus aspirin [WA] [a] DuoCover [AV] [a] Piax Plus Aspirin [AF]	[a] Chem mart Clopidogrel/Aspirin 75/100 [CH] [a] Clopidogrel/Aspirin Sandoz 75/100 [SZ] [a] CoPlavix [SW] [a] DuoPlidogrel [GZ] [a] Terry White Chemists Clopidogrel/Aspirin 75/100 [TW]

▪ DIPYRIDAMOLE

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

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- The treatment must be as adjunctive therapy with low-dose aspirin.

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- Patient must be one in whom low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding.

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Clinical criteria:

- Patient must have a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or non-steroidal anti-inflammatory drugs (NSAIDs).

dipyridamole 200 mg modified release capsule, 60

8335Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	36.32	37.53	Persantin SR [BY]

▪ DIPYRIDAMOLE + ASPIRIN

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

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

dipyridamole 200 mg + aspirin 25 mg modified release capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8382E NP	1	5	..	33.57	34.78	[a] Asasantin SR [BY]	[a] Diasp SR [RW]

▪ EPTIFIBATIDE

Authority required (STREAMLINED)

6435

Coronary artery disease

Treatment criteria:

- Patient must be undergoing non-urgent percutaneous intervention with intracoronary stenting.

eptifibatide 75 mg/100 mL injection, 100 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8684C	3	..	..	*963.40	39.50	Integrilin [MK]

eptifibatide 20 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8683B	2	..	..	*238.91	39.50	Integrilin [MK]

▪ PRASUGREL

Note Shared Care Model:

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

Authority required (STREAMLINED)

6454

Acute coronary syndrome (myocardial infarction or unstable angina)

Clinical criteria:

- The treatment must be managed by percutaneous coronary intervention in combination with aspirin.

prasugrel 10 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9496T NP	1	5	..	97.46	39.50	Effient [LY]

prasugrel 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9495R NP	1	5	..	88.83	39.50	Effient [LY]

▪ TICAGRELOR

Note Shared Care Model:

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

Authority required (STREAMLINED)

5746

Acute coronary syndrome (myocardial infarction or unstable angina)

Clinical criteria:

- The treatment must be in combination with aspirin.

ticagrelor 90 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1418P NP	1	5	..	140.71	39.50	Brilinta [AP]

▪ TIROFIBAN

Note Shared Care Model:

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

Authority required (STREAMLINED)

5782

High risk of unstable angina

Clinical criteria:

- Patient must have new transient or persistent ST-T ischaemic changes, **AND**
- Patient must have pain lasting longer than 20 minutes.

Authority required (STREAMLINED)

5809

High risk of unstable angina

Clinical criteria:

- Patient must have new transient or persistent ST-T ischaemic changes, **AND**
- Patient must have repetitive episodes of angina at rest or during minimal exercise in the previous 12 hours.

Authority required (STREAMLINED)

5691

Non-Q-wave myocardial infarction

tirofiban 12.5 mg/50 mL injection, 50 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8350L NP	1	2	..	231.00	39.50	[a] Aggrastat [AS]	[a] Tirofiban AC [JO]

Enzymes

▪ RETEPLASE

Note Shared Care Model:

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

Restricted benefit

Acute myocardial infarction

Clinical criteria:

- The treatment must be administered within 6 hours of the onset of attack.

reteplase 10 units (17.4 mg) injection [2 x 10 unit vials] (&) inert substance diluent [2 x 10 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8253J NP	‡1	..	..	1965.61	39.50	Rapilysin 10 U [GN]

▪ TENECTEPLASE

Note Shared Care Model:

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

Restricted benefit

Acute myocardial infarction

Clinical criteria:

- The treatment must be administrated within 12 hours of onset of attack.

tenecteplase 8000 units (40 mg) injection [1 vial] (&) inert substance diluent [8 mL syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8526R NP	1	..	..	1861.19	39.50	Metalyse [BY]

tenecteplase 10 000 units (50 mg) injection [1 vial] (&) inert substance diluent [10 mL syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8527T NP	1	..	..	1955.88	39.50	Metalyse [BY]

Direct thrombin inhibitors

▪ BIVALIRUDIN

Authority required (STREAMLINED)

4919

Coronary artery disease

Treatment criteria:

- Patient must be undergoing percutaneous coronary intervention.

bivalirudin 250 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8844L	1	..	..	533.18	39.50	[a] Angiomax [XM]	[a] Bivalirudin APOTEX [TX]

▪ DABIGATRAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4402

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total hip replacement.

Clinical criteria:

- Patient must require up to 30 days supply to complete a course of treatment.

dabigatran etexilate 75 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9320M NP	1	..	..	109.79	39.50	Pradaxa [BY]

dabigatran etexilate 110 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9321N NP	1	..	..	88.38	39.50	Pradaxa [BY]

▪ DABIGATRAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4369

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total hip replacement.

Clinical criteria:

- Patient must require up to 20 days supply to complete a course of treatment.

dabigatran etexilate 75 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9318K NP	2	1	..	*43.99	39.50	Pradaxa [BY]

dabigatran etexilate 110 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9319L NP	2	1	..	*36.85	38.06	Pradaxa [BY]

▪ DABIGATRAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4381

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total knee replacement.

Clinical criteria:

- Patient must require up to 10 days of therapy.

dabigatran etexilate 75 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9322P NP	2	..	..	*43.99	39.50	Pradaxa [BY]

dabigatran etexilate 110 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9323Q NP	2	..	..	*36.85	38.06	Pradaxa [BY]

▪ DABIGATRAN

Note Shared Care Model:

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

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

Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)
4269
Prevention of stroke or systemic embolism
Clinical criteria:
- Patient must have non-valvular atrial fibrillation, **AND**
- Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:
(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;
(ii) age 75 years or older;
(iii) hypertension;
(iv) diabetes mellitus;
(v) heart failure and/or left ventricular ejection fraction 35% or less.

dabigatran etexilate 150 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2769R NP	1	5	..	88.38	39.50	Pradaxa [BY]

dabigatran etexilate 110 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2753X NP	1	5	..	88.38	39.50	Pradaxa [BY]

Direct factor Xa inhibitors

▪ APIXABAN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4402
Prevention of venous thromboembolism
Treatment criteria:
- Patient must be undergoing total hip replacement.

Clinical criteria:
- Patient must require up to 30 days supply to complete a course of treatment.

apixaban 2.5 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5061J NP	1	..	..	92.92	39.50	Eliquis [BQ]

▪ APIXABAN

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
4098
Deep vein thrombosis
Treatment Phase: Initial treatment
Clinical criteria:
- Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**
- Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)
5098
Pulmonary embolism
Treatment Phase: Initial treatment
Clinical criteria:
- Patient must have confirmed acute symptomatic pulmonary embolism.

apixaban 5 mg tablets, 28

10414D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	49.28	39.50	Eliquis [BQ]

▪ APIXABAN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4382
Prevention of venous thromboembolism
Treatment criteria:
- Patient must be undergoing total knee replacement.

Clinical criteria:
- Patient must require up to 15 days of therapy.

Authority required (STREAMLINED)
4409
Prevention of venous thromboembolism
Treatment criteria:
- Patient must be undergoing total hip replacement.

Clinical criteria:
- Patient must require up to 15 days supply to complete a course of treatment.

apixaban 2.5 mg tablet, 30

5054B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	52.01	39.50	Eliquis [BQ]

▪ APIXABAN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4381
Prevention of venous thromboembolism
Treatment criteria:
- Patient must be undergoing total knee replacement.

Clinical criteria:
- Patient must require up to 10 days of therapy.

Authority required (STREAMLINED)
4359
Prevention of venous thromboembolism
Treatment criteria:
- Patient must be undergoing total hip replacement.

Clinical criteria:
- Patient must require up to 10 days supply to complete a course of treatment.

apixaban 2.5 mg tablet, 20

5500L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	38.37	39.50	Eliquis [BQ]

▪ APIXABAN

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
4269
Prevention of stroke or systemic embolism
Clinical criteria:

- Patient must have non-valvular atrial fibrillation, **AND**
- Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;

(ii) age 75 years or older;

(iii) hypertension;

(iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4132

Prevention of recurrent venous thromboembolism

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a history of venous thromboembolism.

apixaban 2.5 mg tablet, 60

2744K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	92.92	39.50	Eliquis [BQ]

NP

▪ APIXABAN

Note Shared Care Model:

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

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

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

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

- Patient must have non-valvular atrial fibrillation, **AND**
- Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;

(ii) age 75 years or older;

(iii) hypertension;

(iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4099

Deep vein thrombosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**
- Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)

5083

Pulmonary embolism

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic pulmonary embolism.

apixaban 5 mg tablet, 60

2735Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	92.92	39.50	Eliquis [BQ]

NP

▪ RIVAROXABAN

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

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

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical

practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4369

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total hip replacement.

Clinical criteria:

- Patient must require up to 20 days supply to complete a course of treatment.

rivaroxaban 10 mg tablet, 10

9465E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	38.26	39.47	Xarelto [BN]

▪ RIVAROXABAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4402

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total hip replacement.

Clinical criteria:

- Patient must require up to 30 days supply to complete a course of treatment.

RIVAROXABAN Tablet 10 mg, 30

9467G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	92.60	39.50	Xarelto [BN]

rivaroxaban 10 mg tablet, 15

9466F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	51.85	39.50	Xarelto [BN]

▪ RIVAROXABAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4381

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total knee replacement.

Clinical criteria:

- Patient must require up to 10 days of therapy.

rivaroxaban 10 mg tablet, 10

9468H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	38.26	39.47	Xarelto [BN]

▪ RIVAROXABAN

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

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

Note Shared Care Model:

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

Authority required (STREAMLINED)

4382

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total knee replacement.

Clinical criteria:

- Patient must require up to 15 days of therapy.

rivaroxaban 10 mg tablet, 15

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9469J NP	1	..	..	51.85	39.50	Xarelto [BN]

▪ RIVAROXABAN

Note Shared Care Model:

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

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

- Patient must have non-valvular atrial fibrillation, **AND**
- Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;

(ii) age 75 years or older;

(iii) hypertension;

(iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

rivaroxaban 15 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2691P NP	1	5	..	87.17	39.50	Xarelto [BN]

▪ RIVAROXABAN

Note Shared Care Model:

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

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

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

Authority required (STREAMLINED)

4098

Deep vein thrombosis

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**
- Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)

4260

Pulmonary embolism

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic pulmonary embolism.

Note Special Pricing Arrangements apply.

rivaroxaban 15 mg tablet, 42

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2160Q NP	1	..	..	125.21	39.50	Xarelto [BN]

▪ RIVAROXABAN

Note Shared Care Model:

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

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

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

Authority required (STREAMLINED)

4099

Deep vein thrombosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**
- Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)

4132

Prevention of recurrent venous thromboembolism

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a history of venous thromboembolism.

Authority required (STREAMLINED)

4268

Pulmonary embolism

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have confirmed acute symptomatic pulmonary embolism.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

- Patient must have non-valvular atrial fibrillation, **AND**
- Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;

(ii) age 75 years or older;

(iii) hypertension;

(iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

Note Special Pricing Arrangements apply.

---

rivaroxaban 20 mg tablet, 28

2268J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	87.17	39.50	Xarelto [BN]

Other antithrombotic agents

▪ FONDAPARINUX

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

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

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

Authority required (STREAMLINED)

5781

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing major hip surgery.

Authority required (STREAMLINED)

5808

Prevention of venous thromboembolism

Treatment criteria:

- Patient must be undergoing total knee replacement.

FONDAPARINUX SODIUM Injection 2.5 mg in 0.5 mL single dose pre-filled syringe, 2

8775W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3.5	..	..	*127.04	39.50	Arixtra [AS]

▪ ANTIHEMORRHAGICS

ANTIFIBRINOLYTICS

Amino acids

▪ TRANEXAMIC ACID

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

tranexamic acid 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2180R NP	1	2	..	43.61	39.50	[a] APO-Tranexamic Acid [TX]	[a] Cyklokapron [PF]

▪ ANTIANEMIC PREPARATIONS

IRON PREPARATIONS

Iron bivalent, oral preparations

▪ FERROUS FUMARATE

Restricted benefit
For treatment of a patient identifying as Aboriginal or Torres Strait Islander

ferrous fumarate 200 mg (equivalent to 65.7 mg of elemental iron) tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8985X NP	1	1	..	17.76	18.97	Ferro-tab [AE]

▪ FERROUS SULFATE

ferrous sulfate heptahydrate 30 mg/mL (iron 6 mg/mL) oral liquid, 250 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8815Y NP	‡1	2	..	21.77	22.98	Ferro-Liquid [AE]

Iron, parenteral preparations

▪ IRON

iron (as ferric carboxymaltose) 500 mg/10 mL injection, 1 x 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10104T NP	2	1	..	*307.49	39.50	ferinject [VL]

▪ IRON POLYMALTOSE

iron (as polymaltose) 100 mg/2 mL injection, 5 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2593L NP	1	..	..	23.69	24.90	Ferrosig [SI]

▪ IRON POLYMALTOSE

Authority required (STREAMLINED)
4302
Iron deficiency anaemia
Treatment criteria:
- Patient must be undergoing chronic haemodialysis.

iron (as polymaltose) 100 mg/2 mL injection, 5 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2805P NP	1	5	..	23.69	24.90	Ferrosig [SI]

▪ IRON SUCROSE

iron (as sucrose) 100 mg/5 mL injection, 5 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10229J NP	1	..	..	40.06	39.50	Venofer [AS]

▪ IRON SUCROSE

Authority required (STREAMLINED)
4302
Iron deficiency anaemia
Treatment criteria:
- Patient must be undergoing chronic haemodialysis.

iron (as sucrose) 100 mg/5 mL injection, 5 x 5 mL ampoules

8807M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	40.06	39.50	Venofer [AS]

Iron in combination with folic acid

▪ FERROUS FUMARATE + FOLIC ACID

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

ferrous fumarate 310 mg (equivalent to 100 mg elemental iron) + folic acid 350 microgram tablet, 60

9011G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	18.78	19.99	Ferro-f-tab [AE]

VITAMIN B12 AND FOLIC ACID

Vitamin B12 (cyanocobalamin and analogues)

▪ HYDROXOCOBALAMIN

Note One injection of hydroxocobalamin 1 mg every three months provides appropriate maintenance therapy in vitamin B_{12} deficiencies.

Note Pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as acetate) in 1 mL and pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as chloride) in 1 mL are equivalent for the purposes of substitution.

Restricted benefit

Pernicious anaemia

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Proven vitamin B12 deficiencies other than pernicious anaemia

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

Restricted benefit

Anaemias associated with vitamin B12 deficiency

Clinical criteria:

- Patient must have had a gastrectomy, **AND**
- The treatment must be for prophylaxis.

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

2162T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.36	16.57	[a] Cobal-B12 [JU]	[a] Vita-B12 [GH]

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

9048F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.36	16.57	[a] Hydroxo-B12 [AS]	[a] Neo-B12 [PF]

Folic acid and derivatives

▪ FOLIC ACID

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

folic acid 500 microgram tablet, 100

2958Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*15.15	16.36	[a] Foltabs 500 [PP]	[a] Megafol 0.5 [AF]

▪ FOLIC ACID

Note The 5 mg strength tablet should be used in malabsorption states only.

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

folic acid 5 mg tablet, 100

1437P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	1	..	*17.37	18.58	Megafol 5 [AF]

BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS

BLOOD AND RELATED PRODUCTS

Blood substitutes and plasma protein fractions

PENTASTARCH + SODIUM CHLORIDE

HYDROXYETHYL STARCH 130/0.4 I.V. infusion 30 g per 500 mL, 500 mL, 1

9487H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	..	..	*44.17	39.50	Voluven 6% [PK]

SUCCINYLATED GELATIN

succinylated gelatin 20 g/500 mL injection, 500 mL bag

8444K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	..	..	*44.17	39.50	Gelofusine [BR]

OTHER HEMATOLOGICAL AGENTS

OTHER HEMATOLOGICAL AGENTS

Drugs used in hereditary angioedema

ICATIBANT

Note Icatibant should be provided in the framework of a comprehensive hereditary angioedema prophylaxis program and an emergency Action Plan including training in recognition of the symptoms of hereditary angioedema and the self-administration of icatibant. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au)

Authority required

Anticipated emergency treatment of an acute attack of hereditary angioedema

Treatment Phase: Initial

Clinical criteria:

- Patient must have confirmed diagnosis of C1-esterase inhibitor deficiency, **AND**
- Patient must have been assessed to be at significant risk of an acute attack of hereditary angioedema, **AND**
- The condition must be assessed by a clinical immunologist; OR
- The condition must be assessed by a respiratory physician; OR
- The condition must be assessed by a specialist allergist; OR
- The condition must be assessed by a general physician experienced in the management of patients with hereditary angioedema.

The name of the specialist consulted must be provided at the time of application for initial supply.

The date of the pathology report and name of the Approved Pathology Authority must be provided at the time of application.

Increased maximum quantities will be limited to 12 injections per authority prescription.

Authority required

Anticipated emergency treatment of an acute attack of hereditary angioedema

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition.

Increased maximum quantities will be limited to 12 injections per authority prescription.

icatibant 30 mg/3 mL injection, 3 mL syringe

1976B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	2574.52	39.50	Firazyr [ZI]

CARDIOVASCULAR SYSTEM

CARDIAC THERAPY

CARDIAC GLYCOSIDES

Digitalis glycosides

DIGOXIN

Note Shared Care Model:

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

digoxin 50 microgram/mL oral liquid, 60 mL

3164M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*41.29	39.50	Lanoxin [QA]

digoxin 62.5 microgram tablet, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2605D NP	1	1	..	14.57	15.78	[a] Sigmaxin-PG [FM]
			[B]2.56	17.13	15.78	[a] Lanoxin-PG [QA]

digoxin 250 microgram tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1322N NP	1	1	..	14.82	16.03	[a] Sigmaxin [FM]
			[B]2.56	17.38	16.03	[a] Lanoxin [QA]

ANTIARRHYTHMICS, CLASS I AND III

Antiarrhythmics, class Ia

▪ DISOPYRAMIDE

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

disopyramide 100 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2923W NP	1	5	..	29.85	31.06	Rythmodan [SW]

Antiarrhythmics, class Ib

▪ LIGNOCAINE

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

lignocaine hydrochloride anhydrous 500 mg/5 mL injection, 10 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2876J NP	1	..	..	30.23	31.44	Xylocard 500 [AS]

Antiarrhythmics, class Ic

▪ FLECAINIDE

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

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

Restricted benefit
Serious supra-ventricular cardiac arrhythmias

Restricted benefit
Serious ventricular cardiac arrhythmias

Clinical criteria:

- The treatment must be initiated in a hospital.

flecainide acetate 100 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1090J NP	1	5	..	39.45	39.50	[a] Flecainide Sandoz [SZ] [a] Tambocor [IA]	[a] Flecatab [AF]

flecainide acetate 50 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1088G NP	1	5	..	33.97	35.18	[a] Flecainide Sandoz [SZ]	[a] Tambocor [IA]

Antiarrhythmics, class III

▪ AMIODARONE

Note This drug has been reported to cause frequent and potentially serious toxicity.

Note Regular monitoring of hepatic and thyroid function is recommended.

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

Restricted benefit
Severe cardiac arrhythmias

amiodarone hydrochloride 100 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2344J NP	1	5	..	15.44	16.65	[a] Aratac 100 [AF]	[a] Cordarone X 100 [SW]

amiodarone hydrochloride 200 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2343H NP	1	5	..	18.83	20.04	[a] Amiodarone Sandoz [SZ] [a] Aratac 200 [AF] [a] GenRx Amiodarone [GX]	[a] APO-Amiodarone [TX] [a] Cordarone X 200 [SW] [a] Rithmik 200 [RW]

▪ SOTALOL

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

Restricted benefit
Severe cardiac arrhythmias

sotalol hydrochloride 160 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2043M NP	1	5	..	18.00	19.21	[a] APO-Sotalol [TX] [a] Solavert [RF]	[a] Cardol [AF] [a] Sotalol Sandoz [SZ]
			[B]4.33	22.33	19.21	[a] Sotacor [RW]	

sotalol hydrochloride 80 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8398B NP	1	5	..	14.30	15.51	[a] APO-Sotalol [TX] [a] Solavert [RF]	[a] Cardol [AF] [a] Sotalol Sandoz [SZ]
			[B]4.33	18.63	15.51	[a] Sotacor [RW]	

CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES

Adrenergic and dopaminergic agents

▪ ADRENALINE

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1016L NP	1	1	..	22.58	23.79	Link Medical Products Pty Ltd [LM]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5004J DP	1	..	..	22.58	23.79	Link Medical Products Pty Ltd [LM]

▪ ADRENALINE

Note The auto-injector should be provided in the framework of a comprehensive anaphylaxis prevention program and an emergency action plan including training in recognition of the symptoms of anaphylaxis and the use of the auto-injector device. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au.)

Note Authority approvals will be limited to a maximum quantity of 2 auto-injectors at any one time.

Note No applications for repeats will be authorised.

Authority required
Acute allergic reaction with anaphylaxis
Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment
Clinical criteria:

- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a clinical immunologist; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with an allergist; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a paediatrician; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a respiratory physician.

The name of the specialist consulted must be provided at the time of application for initial supply.

Authority required
Acute allergic reaction with anaphylaxis
Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment
Clinical criteria:

- Patient must have been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis.

Authority required
Acute allergic reaction with anaphylaxis
Treatment Phase: Continuing sole PBS-subsidised supply for anticipated emergency treatment
Clinical criteria:
- Patient must have previously been issued with an authority prescription for this drug.

adrenaline 300 microgram/0.3 mL injection, 1 dose

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8698T NP	1	..	..	97.10	39.50	EpiPen [AL]

adrenaline 150 microgram/0.3 mL injection, 1 dose

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8697R NP	1	..	..	97.10	39.50	EpiPen Jr. [AL]

VASODILATORS USED IN CARDIAC DISEASES

Organic nitrates

▪ GLYCERYL TRINITRATE

glyceryl trinitrate 10 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1516T NP	1	5	..	32.36	33.57	Transiderm-Nitro 50 [SZ]

glyceryl trinitrate 10 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8011P NP	1	5	..	32.36	33.57	Nitro-Dur 10 [MK]

glyceryl trinitrate 10 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8028M NP	1	5	..	32.36	33.57	Minitran 10 [IA]

glyceryl trinitrate 300 microgram sublingual tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11027J NP	‡1	5	..	18.40	19.61	Nitrostat [PF]

glyceryl trinitrate 300 microgram sublingual tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11051P DP	‡1	..	..	18.40	19.61	Nitrostat [PF]

glyceryl trinitrate 5 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1515R NP	1	5	..	27.31	28.52	Transiderm-Nitro 25 [SZ]

glyceryl trinitrate 5 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8010N NP	1	5	..	27.31	28.52	Nitro-Dur 5 [MK]

glyceryl trinitrate 5 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8027L NP	1	5	..	27.31	28.52	Minitran 5 [IA]

glyceryl trinitrate 600 microgram sublingual tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1459T NP	‡1	5	..	18.40	19.61	Nitrostat [PF] [a] Lycinate [RF]
			[B]2.56	20.96	19.61	[a] Anginine Stabilised [RW]

glyceryl trinitrate 600 microgram sublingual tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5108W DP	‡1	..	..	18.40	19.61	Nitrostat [PF] [a] Lycinate [RF]
			[B]2.56	20.96	19.61	[a] Anginine Stabilised [RW]

glyceryl trinitrate 15 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8026K NP	1	5	..	32.36	33.57	Nitro-Dur 15 [MK]

glyceryl trinitrate 15 mg/24 hours patch, 30

8119H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	32.36	33.57	Minitran 15 [IA]

▪ GLYCERYL TRINITRATE

Note The spray should not be inhaled.

glyceryl trinitrate 400 microgram/actuation oral spray, 200 actuations

8171C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	23.01	24.22	Nitrolingual Pumpspray [SW]

▪ ISOSORBIDE DINITRATE

isosorbide dinitrate 5 mg sublingual tablet, 100

2588F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*18.17	19.38	Isordil Sublingual [RW]

▪ ISOSORBIDE MONONITRATE

isosorbide mononitrate 60 mg modified release tablet, 30

1558B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.77	15.98	[a] Chem mart Isosorbide Mononitrate [CH]	[a] Duride [AF]
						[a] GenRx Isosorbide Mononitrate [GX]	[a] Isomonit [SZ]
						[a] Isosorbide AN [EA]	[a] Terry White Chemists Isosorbide Mononitrate [TW]
			[B]2.48	17.25	15.98	[a] Monodur 60 mg [PM]	
			[B]3.37	18.14	15.98	[a] Imdur Durule [AP]	

isosorbide mononitrate 120 mg modified release tablet, 30

8273K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.41	19.62	[a] Monodur 120 mg [PM]
			[B]3.37	21.78	19.62	[a] Imdur 120 mg [AP]

Other vasodilators used in cardiac diseases

▪ NICORANDIL

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

nicorandil 20 mg tablet, 60

8229D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	30.56	31.77	[a] Ikorel [SW]	[a] Ikotab [QA]

nicorandil 10 mg tablet, 60

8228C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	25.07	26.28	[a] Ikorel [SW]	[a] Ikotab [QA]

▪ PERHEXILINE

Note Regular monitoring of drug serum levels is recommended.

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

Authority required (STREAMLINED)

5592
Angina
Clinical criteria:

- The condition must not be responding to other therapy.

perhexiline maleate 100 mg tablet, 100

1822X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.62	39.50	Pexsig [QA]

OTHER CARDIAC PREPARATIONS

Other cardiac preparations

▪ IVABRADINE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4979

Chronic heart failure

Clinical criteria:

- Patient must be symptomatic with NYHA classes II or III, **AND**
- Patient must be in sinus rhythm, **AND**
- Patient must have a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%, **AND**
- Patient must have a resting heart rate at or above 77 bpm at the time ivabradine treatment is initiated, **AND**
- Patient must receive concomitant optimal standard chronic heart failure treatment, which must include the maximum tolerated dose of a beta-blocker, unless contraindicated or not tolerated.

Resting heart rate should be measured by ECG or echocardiography, after 5 minutes rest.

The ECG or echocardiography, result must be documented in the patient's medical records when treatment is initiated.

ivabradine 5 mg tablet, 56

10012Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	56.25	39.50	Coralan [SE]

ivabradine 7.5 mg tablet, 56

2960T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	56.25	39.50	Coralan [SE]

▪ ANTIHYPERTENSIVES

ANTIADRENERGIC AGENTS, CENTRALLY ACTING

Methyldopa

▪ METHYLDOPA

methyldopa 250 mg tablet, 100

1629R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	19.89	21.10	[a] Hydopa [AF]
			[B]3.08	22.97	21.10	[a] Aldomet [AS]

Imidazoline receptor agonists

▪ CLONIDINE

clonidine hydrochloride 100 microgram tablet, 100

3145M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.67	27.88	[a] APO-Clonidine [TX]	[a] Catapres 100 [BY]

clonidine hydrochloride 150 microgram tablet, 100

3141H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	32.62	33.83	Catapres [BY]

▪ MOXONIDINE

Restricted benefit

Hypertension

Clinical criteria:

- Patient must be receiving concurrent antihypertensive therapy.

moxonidine 200 microgram tablet, 30

9019Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	21.92	23.13	Physiotens [GO]

moxonidine 400 microgram tablet, 30

9020R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	29.56	30.77	Physiotens [GO]

ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING

Alpha-adrenoreceptor antagonists

▪ PRAZOSIN

prazosin 1 mg tablet, 100

1479W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.22	16.43	[a] APO-Prazosin [TX] [a] Minipress [PF]	[a] Chem mart Prazosin [CH] [a] Terry White Chemists Prazosin [TW]

prazosin 5 mg tablet, 100

1478T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.65	22.86	[a] APO-Prazosin [TX] [a] Minipress [PF]	[a] Chem mart Prazosin [CH] [a] Terry White Chemists Prazosin [TW]

prazosin 2 mg tablet, 100

1480X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.97	18.18	[a] APO-Prazosin [TX] [a] Minipress [PF]	[a] Chem mart Prazosin [CH] [a] Terry White Chemists Prazosin [TW]

ARTERIOLAR SMOOTH MUSCLE, AGENTS ACTING ON

Hydrazinophthalazine derivatives

▪ HYDRALAZINE

hydralazine hydrochloride 50 mg tablet, 100

1639G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*21.51	22.72	Alphapress 50 [AF]

hydralazine hydrochloride 25 mg tablet, 100

1640H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*20.07	21.28	Alphapress 25 [AF]

Pyrimidine derivatives

▪ MINOXIDIL

Note Continuing Therapy Only:

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

Restricted benefit

Severe refractory hypertension

Clinical criteria:

- The treatment must be initiated by a consultant physician.

minoxidil 10 mg tablet, 100

2313R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	57.59	39.50	Loniten [PF]

▪ DIURETICS

LOW-CEILING DIURETICS, THIAZIDES

Thiazides, plain

▪ HYDROCHLOROTHIAZIDE

hydrochlorothiazide 25 mg tablet, 100

1484D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	23.34	24.55	Dithiazide [PL]

LOW-CEILING DIURETICS, EXCL. THIAZIDES

Sulfonamides, plain

▪ CHLORTALIDONE

chlortalidone 25 mg tablet, 50

1585K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	1	..	*20.29	21.50	Hygroton 25 [GH]

▪ INDAPAMIDE

indapamide hemihydrate 1.5 mg modified release tablet, 90

8532C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	18.80	20.01	[a] APO-Indapamide SR [TX]	[a] Chem mart Indapamide SR [CH]
						[a] INDAPAMIDE AN SR [EA]	[a] Odaplix SR [AF]
						[a] Tenaxil SR [RW]	[a] Terry White Chemists Indapamide SR [TW]
			[B]6.15	24.95	20.01	[a] Natrilix SR [SE]	

indapamide hemihydrate 2.5 mg tablet, 90

2436F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	16.37	17.58	[a] Dapa-Tabs [AF]	[a] GenRx Indapamide [GX]
						[a] Indapamide AN [EA]	[a] Indapamide Sandoz [SZ]
						[a] Insig [RW]	
			[B]6.58	22.95	17.58	[a] Natrilix [SE]	

HIGH-CEILING DIURETICS

Sulfonamides, plain

▪ FUROSEMIDE (FRUSEMIDE)

furosemide (frusemide) 10 mg/mL oral liquid, 30 mL

2411X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	3	..	27.11	28.32	Lasix [SW]

furosemide (frusemide) 40 mg tablet, 100

2412Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	12.77	13.98	Urex [RW]	
						[a] APO-Frusemide [TX]	[a] Chem mart Frusemide [CH]
						[a] Frusax [ER]	[a] Frusemide RBX [RA]
						[a] Frusemide Sandoz [SZ]	[a] FUROSEMIDE AN [EA]
						[a] Terry White Chemists Frusemide [TW]	[a] Uremide [AF]
			[B]1.85	14.62	13.98	[a] Lasix [SW]	

furosemide (frusemide) 500 mg tablet, 50

2415D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	18.92	20.13	Urex-Forte [RW]

furosemide (frusemide) 20 mg/2 mL injection, 5 x 2 mL ampoules

2413B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.24	14.45	[a] Frusemide-Claris [AE]	[a] Frusemide Sandoz [SZ]
						[a] Lasix [SW]	

▪ FUROSEMIDE (FRUSEMIDE)

Note For item codes 2414C and 1810G, pharmaceutical benefits that have the form tablet 20 mg are equivalent for the purposes of substitution.

furosemide (frusemide) 20 mg tablet, 100

2414C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	12.77	13.98	[a] APO-Frusemide [TX]	[a] Chem mart Frusemide [CH]
						[a] Frusemide RBX [RA]	[a] FUROSEMIDE AN [EA]
						[a] Terry White Chemists Frusemide [TW]	

furosemide (frusemide) 20 mg tablet, 50

1810G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	1	..	*12.77	13.98	[a] Urex-M [RW]
			[B]1.46	*14.23	13.98	[a] Lasix-M [SW]

Aryloxyacetic acid derivatives

▪ ETACRYNIC ACID

Restricted benefit

Patients hypersensitive to other oral diuretics

etacrynic acid 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8748K NP	2	1	..	*175.93	39.50	Edecrin [FK]

POTASSIUM-SPARING AGENTS

Aldosterone antagonists

▪ EPLERENONE

Caution Serum electrolytes should be checked regularly

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4937

Heart failure with a left ventricular ejection fraction of 40% or less

Clinical criteria:

- The condition must occur within 3 to 14 days following an acute myocardial infarction, **AND**
- The treatment must be commenced within 14 days of an acute myocardial infarction.

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

eplerenone 50 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8880J NP	1	5	..	88.24	39.50	[a] Eplerenone AN [EA] [a] Inpler [AF]	[a] ESPLER [RW] [a] Inspra [PF]

eplerenone 25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8879H NP	1	5	..	88.24	39.50	[a] Eplerenone AN [EA] [a] Inpler [AF]	[a] ESPLER [RW] [a] Inspra [PF]

▪ SPIRONOLACTONE

Caution Serum electrolytes should be checked regularly

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

spironolactone 100 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2340E NP	1	5	..	30.83	32.04	[a] Spiractin 100 [AF]
			[B]7.49	38.32	32.04	[a] Aldactone [PF]

spironolactone 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2339D NP	1	5	..	16.11	17.32	[a] Spiractin 25 [AF]
			[B]7.50	23.61	17.32	[a] Aldactone [PF]

DIURETICS AND POTASSIUM-SPARING AGENTS IN COMBINATION

Low-ceiling diuretics and potassium-sparing agents

▪ AMILORIDE + HYDROCHLOROTHIAZIDE

Caution Serum electrolytes should be checked regularly.

amiloride hydrochloride dihydrate 5 mg + hydrochlorothiazide 50 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1486F NP	2	1	..	*17.25	18.46	Moduretic [AS]

▪ HYDROCHLOROTHIAZIDE + TRIAMTERENE

Caution Serum electrolytes should be checked regularly.

hydrochlorothiazide 25 mg + triamterene 50 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1280J NP	1	1	..	16.72	17.93	Hydrene 25/50 [AF]

▪ PERIPHERAL VASODILATORS

PERIPHERAL VASODILATORS

Other peripheral vasodilators

▪ PHENOXYBENZAMINE

Note Continuing Therapy Only:

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

Restricted benefit

Phaeochromocytoma

Restricted benefit

Neurogenic urinary retention

phenoxybenzamine hydrochloride 10 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1166J NP	3	5	..	*997.75	39.50	Amdipharm Mercury (Australia) Pty Limited [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1862B NP	1	5	..	1103.27	39.50	Dibenyline [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9286R NP	1	5	..	1103.27	39.50	Dibenzyline [BZ]

▪ BETA BLOCKING AGENTS

BETA BLOCKING AGENTS

Beta blocking agents, non-selective

▪ OXPRENOLOL

oxprenolol hydrochloride 40 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2961W NP	1	5	..	46.54	39.50	Corbeton 40 [AF]

▪ PINDOLOL

pindolol 5 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3062E NP	1	5	..	31.97	33.18	Barbloc 5 [AF]

▪ PROPRANOLOL

propranolol hydrochloride 160 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2899N NP	1	5	..	17.81	19.02	Deralin 160 [AF]

propranolol hydrochloride 10 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2565B NP	1	5	..	13.84	15.05	[a] APO-Propranolol [TX]
			[B]2.99	16.83	15.05	[a] Deralin 10 [AF]
			[B]3.75	17.59	15.05	[a] Inderal [AP]

propranolol hydrochloride 40 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2566C NP	1	5	..	14.11	15.32	[a] APO-Propranolol [TX]
			[B]2.99	17.10	15.32	[a] Deralin 40 [AF]
			[B]3.75	17.86	15.32	[a] Inderal [AP]

Beta blocking agents, selective

▪ ATENOLOL

atenolol 50 mg tablet, 30

1081X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.23	13.44	[a] APO-Atenolol [TX] [a] Atenolol-GA [ED] [a] Atenolol Sandoz [SZ] [a] Noten [AF] [a] Tensig [RW]	[a] Atenolol Amneal [EF] [a] Atenolol GH [GQ] [a] Chem mart Atenolol [CH] [a] Tenolten 50 [DO] [a] Terry White Chemists Atenolol [TW]
			[B]2.44	14.67	13.44	[a] Tenormin [AP]	

▪ ATENOLOL

Restricted benefit

For a patient who is unable to take a solid dose form of atenolol.

atenolol 50 mg/10 mL oral liquid, 300 mL

2243C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	29.37	30.58	Atenolol-AFT [AE]

▪ BISOPROLOL

Note Continuing Therapy Only:

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

Restricted benefit

Moderate to severe heart failure

Clinical criteria:

- Patient must be stabilised on conventional therapy, which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated.

bisoprolol fumarate 5 mg tablet, 28

8605X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.52	20.73	[a] APO-Bisoprolol [TX] [a] Bicard 5 [RW] [a] Bisoprolol generichealth [GQ] [a] Bispro 5 [AF] [a] Terry White Chemists Bisoprolol [TW]	[a] Beprol 5 [DO] [a] Bisoprolol AN [EA] [a] Bisoprolol Sandoz [SZ] [a] Chem mart Bisoprolol [CH]
			[B]6.70	26.22	20.73	[a] Bicor [AL]	

bisoprolol fumarate 2.5 mg tablet, 28

8604W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.84	19.05	[a] APO-Bisoprolol [TX] [a] Bicard 2.5 [RW] [a] Bisoprolol generichealth [GQ] [a] Bispro 2.5 [AF] [a] Terry White Chemists Bisoprolol [TW]	[a] Beprol 2.5 [DO] [a] Bisoprolol AN [EA] [a] Bisoprolol Sandoz [SZ] [a] Chem mart Bisoprolol [CH]
			[B]6.70	24.54	19.05	[a] Bicor [AL]	

bisoprolol fumarate 10 mg tablet, 28

8606Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.63	22.84	[a] APO-Bisoprolol [TX] [a] Bicard 10 [RW] [a] Bisoprolol generichealth [GQ] [a] Bispro 10 [AF] [a] Terry White Chemists Bisoprolol [TW]	[a] Beprol 10 [DO] [a] Bisoprolol AN [EA] [a] Bisoprolol Sandoz [SZ] [a] Chem mart Bisoprolol [CH]
			[B]6.70	28.33	22.84	[a] Bicor [AL]	

▪ METOPROLOL SUCCINATE

Note Continuing Therapy Only:

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

Restricted benefit

Moderate to severe heart failure

Clinical criteria:

- Patient must be stabilised on conventional therapy, which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated.

METOPROLOL SUCCINATE Tablet 47.5 mg (controlled release), 30

8733P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	50.07	39.50	[a] Metrol-XL 47.5 [RW] [a] Toprol-XL 47.5 [AP]	[a] Minax XL [AF]

METOPROLOL SUCCINATE Tablet 190 mg (controlled release), 30

8735R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	71.97	39.50	[a] Metrol-XL 190 [RW] [a] Toprol-XL 190 [AP]	[a] Minax XL [AF]

METOPROLOL SUCCINATE Tablet 95 mg (controlled release), 30

8734Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	59.80	39.50	[a] Metrol-XL 95 [RW] [a] Toprol-XL 95 [AP]	[a] Minax XL [AF]

METOPROLOL SUCCINATE Tablet 23.75 mg (controlled release), 15

8732N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	19.35	20.56	[a] Metrol-XL 23.75 [RW] [a] Toprol-XL 23.75 [AP]	[a] Minax XL [AF]

▪ METOPROLOL TARTRATE

METOPROLOL TARTRATE Tablet 100 mg, 60

1325R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.52	14.73	[a] Metoprolol AN [EA] [a] Mistrom [ER] [b] APO-Metoprolol [TX] [b] Metoprolol Sandoz [SZ] [b] Minax 100 [AF]	[a] Metoprolol RBX [RA] [b] Chem mart Metoprolol [CH] [b] Metrol 100 [RW] [b] Terry White Chemists Metoprolol [TW]
			[B]1.80	15.32	14.73	[a] Lopresor 100 [NV]	
			[B]3.76	17.28	14.73	[b] Betaloc [AP]	

METOPROLOL TARTRATE Tablet 50 mg, 100

1324Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.99	14.20	[a] Metoprolol AN [EA] [a] Mistrom [ER] [b] APO-Metoprolol [TX] [b] Metoprolol Sandoz [SZ] [b] Minax 50 [AF]	[a] Metoprolol RBX [RA] [b] Chem mart Metoprolol [CH] [b] Metrol 50 [RW] [b] Terry White Chemists Metoprolol [TW]
			[B]1.80	14.79	14.20	[a] Lopresor 50 [NV]	
			[B]3.76	16.75	14.20	[b] Betaloc [AP]	

▪ NEBIVOLOL

Note Continuing Therapy Only:

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

Restricted benefit

Moderate to severe heart failure

Clinical criteria:

- Patient must be stabilised on conventional therapy, which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated.

nebivolol 5 mg tablet, 28

9311C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	58.17	39.50	Nebilet [FK]

nebivolol 10 mg tablet, 28

9312D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	64.29	39.50	Nebilet [FK]

nebivolol 1.25 mg tablet, 28

9316H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*48.81	39.50	Nebilet [FK]

Alpha and beta blocking agents

▪ CARVEDILOL

Note Continuing Therapy Only:

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

Restricted benefit

Moderate to severe heart failure

Clinical criteria:

- Patient must be stabilised on conventional therapy, which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated.

Restricted benefit

Patients receiving this drug as a pharmaceutical benefit prior to 1 August 2002

carvedilol 6.25 mg tablet, 60

8256M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.70	20.91	[a] APO-Carvedilol [TX] [a] Carvedilol Sandoz [SZ] [a] Dicarz [AF] [a] Terry White Chemists Carvedilol 6.25 mg [TW] [a] Volirop 6.25 [DO]	[a] Carvedilol AN [EA] [a] Chem mart Carvedilol 6.25 mg [CH] [a] Dilatrend 6.25 [PB] [a] Vedilol 6.25 [RW]

carvedilol 3.125 mg tablet, 30

8255L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.13	15.34	[a] APO-Carvedilol [TX] [a] Chem mart Carvedilol 3.125 mg [CH] [a] Vedilol 3.125 [RW]	[a] Carvedilol AN [EA] [a] Terry White Chemists Carvedilol 3.125 mg [TW] [a] Volirop 3.125 [DO]

carvedilol 12.5 mg tablet, 60

8257N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.86	23.07	[a] APO-Carvedilol [TX] [a] Carvedilol Sandoz [SZ] [a] Dicarz [AF] [a] Terry White Chemists Carvedilol 12.5 mg [TW] [a] Volirop 12.5 [DO]	[a] Carvedilol AN [EA] [a] Chem mart Carvedilol 12.5 mg [CH] [a] Dilatrend 12.5 [PB] [a] Vedilol 12.5 [RW]

carvedilol 25 mg tablet, 60

8258P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	24.55	25.76	[a] APO-Carvedilol [TX] [a] Carvedilol Sandoz [SZ] [a] Dicarz [AF] [a] Terry White Chemists Carvedilol 25 mg [TW] [a] Volirop 25 [DO]	[a] Carvedilol AN [EA] [a] Chem mart Carvedilol 25 mg [CH] [a] Dilatrend 25 [PB] [a] Vedilol 25 [RW]

▪ LABETALOL

labetalol hydrochloride 100 mg tablet, 100

1566K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	24.34	25.55	[a] Presolol 100 [AF]
			[B]3.50	27.84	25.55	[a] Trandate [QA]

labetalol hydrochloride 200 mg tablet, 100

1567L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	24.34	25.55	[a] Presolol 200 [AF]
			[B]3.50	27.84	25.55	[a] Trandate [QA]

▪ CALCIUM CHANNEL BLOCKERS

SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY VASCULAR EFFECTS

Dihydropyridine derivatives

▪ AMLODIPINE

amlodipine 5 mg tablet, 30

2751T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.98	13.19	[a] Amlo 5 [RW]	[a] Amlodipine Amneal [EF]
						[a] Amlodipine AN [EA]	[a] Amlodipine GH [GQ]
						[a] Amlodipine Sandoz [SZ]	[a] APO-Amlodipine [TX]
						[a] Auro-Amlodipine 5 [DO]	[a] Blooms the Chemist Amlodipine [IB]
						[a] Chem mart Amlodipine [CH]	[a] Nordip [AF]
						[a] Norvapine [ED]	[a] Ozlodip [RA]
						[a] Pharmacor Amlodipine [CR]	[a] Terry White Chemists Amlodipine [TW]
			[B]9.20	21.18	13.19	[a] Norvasc [PF]	

amlodipine 10 mg tablet, 30

2752W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.67	13.88	[a] Amlo 10 [RW]	[a] Amlodipine Amneal [EF]
						[a] Amlodipine AN [EA]	[a] Amlodipine GH [GQ]
						[a] Amlodipine Sandoz [SZ]	[a] APO-Amlodipine [TX]
						[a] Auro-Amlodipine 10 [DO]	[a] Blooms the Chemist Amlodipine [IB]
						[a] Chem mart Amlodipine [CH]	[a] Nordip [AF]
						[a] Norvapine [ED]	[a] Ozlodip [RA]
						[a] Pharmacor Amlodipine [CR]	[a] Terry White Chemists Amlodipine [TW]
			[B]9.20	21.87	13.88	[a] Norvasc [PF]	

▪ FELODIPINE

felodipine 5 mg modified release tablet, 30

2366M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.12	16.33	[a] Felodil XR 5 [RW]	[a] Felodur ER 5 mg [TX]
						[a] Fendex ER [AF]	
			[B]2.09	17.21	16.33	[a] Plendil ER [GX]	

felodipine 10 mg modified release tablet, 30

2367N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.39	19.60	[a] Felodil XR 10 [RW]	[a] Felodur ER 10 mg [TX]
						[a] Fendex ER [AF]	
			[B]2.09	20.48	19.60	[a] Plendil ER [GX]	

felodipine 2.5 mg modified release tablet, 30

2361G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.90	15.11	[a] Felodur ER 2.5 mg [TX]	[a] Fendex ER [AF]
			[B]2.08	15.98	15.11	[a] Plendil ER [GX]	

▪ LERCANIDIPINE

lercanidipine hydrochloride 20 mg tablet, 28

8679T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.58	15.79	[a] APO-Lercanidipine [TX]	[a] Blooms the Chemist Lercanidipine [IB]
						[a] Chem mart Lercanidipine [CH]	[a] Ledip [RA]
						[a] Lercadip [EA]	[a] Lercan [RW]
						[a] Lercanidipine GH [GQ]	[a] Lercanidipine Sandoz [SZ]
						[a] Terry White Chemists Lercanidipine [TW]	[a] Zircol [AF]
			[B]3.50	18.08	15.79	[a] Zanidip [GO]	

lercanidipine hydrochloride 10 mg tablet, 28

8534E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.19	14.40	[a] APO-Lercanidipine [TX]	[a] Blooms the Chemist Lercanidipine [IB]
						[a] Chem mart Lercanidipine [CH]	[a] Ledip [RA]
						[a] Lercadip [EA]	[a] Lercan [RW]
						[a] Lercanidipine GH [GQ]	[a] Lercanidipine Sandoz [SZ]
						[a] Terry White Chemists Lercanidipine [TW]	[a] Zircol [AF]
			[B]3.50	16.69	14.40	[a] Zanidip [GO]	

▪ NIFEDIPINE

nifedipine 20 mg modified release tablet, 30

8610E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.47	18.68	Adalat Oros 20mg [BN]

nifedipine 10 mg tablet, 60

1694E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.08	17.29	[a] Adefin 10 [AF]
			[B]1.64	17.72	17.29	[a] Adalat 10 [BN]

nifedipine 20 mg tablet, 60

1695F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.23	18.44	[a] Adefin 20 [AF]
			[B]2.29	19.52	18.44	[a] Adalat 20 [BN]

nifedipine 30 mg modified release tablet, 30

1906H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.98	19.19	[a] Addos XR 30 [RW] [a] APO-Nifedipine XR [TX]	[a] Adefin XL 30 [AF]
			[B]2.52	20.50	19.19	[a] Adalat Oros 30 [BN]	

nifedipine 60 mg modified release tablet, 30

1907J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.75	20.96	[a] Addos XR 60 [RW] [a] APO-Nifedipine XR [TX]	[a] Adefin XL 60 [AF]
			[B]2.66	22.41	20.96	[a] Adalat Oros 60 [BN]	

SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT CARDIAC EFFECTS

Phenylalkylamine derivatives

▪ VERAPAMIL

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

verapamil hydrochloride 240 mg modified release tablet, 30

1241H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	19.13	20.34	[a] Cordilox SR [GT]
			[B]3.50	22.63	20.34	[a] Isoptin SR [GO]

verapamil hydrochloride 40 mg tablet, 100

1248Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.96	17.17	Anpec 40 [AF]

verapamil hydrochloride 180 mg modified release tablet, 30

2208F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.12	18.33	[a] Cordilox 180 SR [GT]
			[B]3.50	20.62	18.33	[a] Isoptin 180 SR [GO]

verapamil hydrochloride 80 mg tablet, 100

1250T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.56	19.77	[a] Anpec 80 [AF]
			[B]3.50	22.06	19.77	[a] Isoptin [GO]

Benzothiazepine derivatives

▪ DILTIAZEM

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

diltiazem hydrochloride 360 mg modified release capsule, 30

8480H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.00	24.21	[a] Diltiazem Sandoz CD [SZ]	[a] Vasocardol CD [AV]
			[B]1.90	24.90	24.21	[a] Cardizem CD [SW]	

diltiazem hydrochloride 60 mg tablet, 90

1335G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.15	18.36	[a] Diltiazem Actavis [ED] [a] Diltiazem Sandoz [SZ]	[a] Diltiazem AN [EA]
			[B]1.90	19.05	18.36	[a] Cardizem [SW]	[a] Vasocardol [AV]

diltiazem hydrochloride 180 mg modified release capsule, 30

1312C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.81	19.02	[a] Diltiazem Sandoz CD [SZ]	[a] Vasocardol CD [AV]
			[B]1.90	19.71	19.02	[a] Cardizem CD [SW]	

diltiazem hydrochloride 240 mg modified release capsule, 30

1313D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.18	21.39	[a] Diltiazem Sandoz CD [SZ]	[a] Vasocardol CD [AV]
			[B]1.90	22.08	21.39	[a] Cardizem CD [SW]	

AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM

ACE INHIBITORS, PLAIN

ACE inhibitors, plain

CAPTOPRIL

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

captopril 50 mg tablet, 90

1149L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	20.65	21.86	[a] Captopril Sandoz [SZ]
			[B]3.90	24.55	21.86	[a] Capoten [RW]
			[B]3.94	24.59	21.86	[a] Zedace [AF]

captopril 12.5 mg tablet, 90

1147J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.44	15.65	[a] Captopril Sandoz [SZ]
			[B]3.95	18.39	15.65	[a] Zedace [AF]

captopril 25 mg tablet, 90

1148K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.94	17.15	[a] Captopril Sandoz [SZ]
			[B]3.95	19.89	17.15	[a] Zedace [AF]
			[B]4.67	20.61	17.15	[a] Capoten [RW]

CAPTOPRIL

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

Restricted benefit

Patients unable to take a solid dose form of an ACE inhibitor.

captopril 5 mg/mL oral liquid, 95 mL

8760C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	106.91	39.50	Capoten [RW]

ENALAPRIL

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

enalapril maleate 5 mg tablet, 30

1370D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.96	14.17	[a] Acetec [AL] [a] Enalapril Actavis [ED] [a] Enalapril Sandoz [SZ]	[a] APO-Enalapril [TX] [a] Enalapril generichealth [GQ] [a] Malean [RW]

enalapril maleate 10 mg tablet, 30

1368B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.18	15.39	[a] Acetec [AL] [a] Enalapril Actavis [ED] [a] Enalapril Sandoz [SZ]	[a] APO-Enalapril [TX] [a] Enalapril generichealth [GQ] [a] Malean [RW]
			[B]6.40	20.58	15.39	[a] Renitec [MK]	

enalapril maleate 20 mg tablet, 30

1369C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.01	16.22	[a] Acetec [AL] [a] Enalapril Actavis [ED] [a] Enalapril Sandoz [SZ]	[a] APO-Enalapril [TX] [a] Enalapril generichealth [GQ] [a] Malean [RW]
			[B]6.40	21.41	16.22	[a] Renitec 20 [MK]	

FOSINOPRIL

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

fosinopril sodium 10 mg tablet, 30

1182F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.58	16.79	[a] APO-Fosinopril [TX] [a] Monace 10 [AF]	[a] Fosipril 10 [RW]

fosinopril sodium 20 mg tablet, 30

1183G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.80	19.01	[a] APO-Fosinopril [TX] [a] Monace 20 [AF]	[a] Fosipril 20 [RW]

▪ LISINOPRIL

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

lisinopril 10 mg tablet, 30

2457H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.33	15.54	[a] APO-Lisinopril [TX] [a] Chem mart Lisinopril [CH] [a] Lisinopril AN [EA] [a] Lisinopril Sandoz [SZ] [a] Zinopril 10 [AL]	[a] Auro-Lisinopril 10 [DO] [a] Fibsol 10 [RW] [a] Lisinopril generichealth [GQ] [a] Terry White Chemists Lisinopril [TW]
			[B]3.30	17.63	15.54	[a] Zestril [AP]	

lisinopril 20 mg tablet, 30

2458J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.17	16.38	[a] APO-Lisinopril [TX] [a] Chem mart Lisinopril [CH] [a] Lisinopril AN [EA] [a] Lisinopril Sandoz [SZ] [a] Zinopril 20 [AL]	[a] Auro-Lisinopril 20 [DO] [a] Fibsol 20 [RW] [a] Lisinopril generichealth [GQ] [a] Terry White Chemists Lisinopril [TW]
			[B]3.30	18.47	16.38	[a] Zestril [AP]	

lisinopril 5 mg tablet, 30

2456G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.25	14.46	[a] APO-Lisinopril [TX] [a] Chem mart Lisinopril [CH] [a] Lisinopril AN [EA] [a] Lisinopril Sandoz [SZ] [a] Zinopril 5 [AL]	[a] Auro-Lisinopril 5 [DO] [a] Fibsol 5 [RW] [a] Lisinopril generichealth [GQ] [a] Terry White Chemists Lisinopril [TW]
			[B]3.30	16.55	14.46	[a] Zestril [AP]	

▪ PERINDOPRIL

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

Note Pharmaceutical benefits that have the form perindopril erbumine 2 mg tablet and pharmaceutical benefits that have the form perindopril arginine 2.5 mg tablet are equivalent for the purposes of substitution.

perindopril erbumine 2 mg tablet, 30

3050M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.63	13.84	[a] APO-Perindopril [TX] [a] Chem mart Perindopril [CH] [a] Indosyl Mono 2 [RW] [a] Perindopril Actavis 2 [EA] [a] Terry White Chemists Perindopril [TW]	[a] Blooms the Chemist Perindopril [IB] [a] Idaprex 2 [SZ] [a] Perindo [AF] [a] Perindopril AN [EF]

perindopril arginine 2.5 mg tablet, 30

9006B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.63	13.84	[a] APO-Perindopril Arginine [TX]	[a] PREXUM 2.5 [RW]
			[B]6.32	18.95	13.84	[a] Coversyl 2.5mg [SE]	

▪ PERINDOPRIL

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

Note Pharmaceutical benefits that have the form perindopril erbumine 4 mg tablet and pharmaceutical benefits that have the form perindopril arginine 5 mg tablet are equivalent for the purposes of substitution.

perindopril erbumine 4 mg tablet, 30

3051N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.95	15.16	[a] APO-Perindopril [TX]	[a] Blooms the Chemist Perindopril [IB]
						[a] Chem mart Perindopril [CH]	[a] Idaprex 4 [SZ]
						[a] Indosyl Mono 4 [RW]	[a] Perindo [AF]
						[a] Perindopril Actavis 4 [ED]	[a] Perindopril AN [EF]
						[a] Perindopril generichealth [GQ]	[a] Terry White Chemists Perindopril [TW]

perindopril arginine 5 mg tablet, 30

9007C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.95	15.16	[a] APO-Perindopril Arginine [TX]	[a] PREXUM 5 [RW]
			[B]6.01	19.96	15.16	[a] Coversyl 5mg [SE]	

▪ PERINDOPRIL

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

Note Pharmaceutical benefits that have the form perindopril erbumine 8 mg tablet and pharmaceutical benefits that have the form perindopril arginine 10 mg tablet are equivalent for the purposes of substitution.

perindopril arginine 10 mg tablet, 30

9008D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.47	16.68	[a] APO-Perindopril Arginine [TX]	[a] PREXUM 10 [RW]
			[B]6.48	21.95	16.68	[a] Coversyl 10mg [SE]	

perindopril erbumine 8 mg tablet, 30

8704D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.47	16.68	[a] APO-Perindopril [TX]	[a] Blooms the Chemist Perindopril [IB]
						[a] Chem mart Perindopril [CH]	[a] Idaprex 8 [SZ]
						[a] Indosyl Mono 8 [RW]	[a] Perindo [AF]
						[a] Perindopril Actavis 8 [ED]	[a] Perindopril AN [EF]
						[a] Perindopril generichealth [GQ]	[a] Terry White Chemists Perindopril [TW]

▪ QUINAPRIL

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

quinapril 10 mg tablet, 30

1969P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.08	16.29	[a] Acquin Aspen 10 [RW]	[a] APO-Quinapril [TX]
						[a] Qpril 10 [AF]	
			[B]4.20	19.28	16.29	[a] Accupril [PF]	

quinapril 20 mg tablet, 30

1970Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.01	17.22	[a] ACQUIN [RF]	[a] Acquin Aspen 20 [RW]
						[a] APO-Quinapril [TX]	[a] Qpril 20 [AF]
						[a] Quinapril generichealth [GQ]	
			[B]4.20	20.21	17.22	[a] Accupril [PF]	

quinapril 5 mg tablet, 30

1968N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.22	15.43	[a] ACQUIN [RF]	[a] Acquin Aspen 5 [RW]
						[a] Qpril 5 [AF]	
			[B]4.20	18.42	15.43	[a] Accupril [PF]	

▪ RAMIPRIL

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

Note Pharmaceutical benefits that have the form ramipril 10 mg tablet and pharmaceutical benefits that have the form ramipril 10 mg capsule are equivalent for the purposes of substitution.

ramipril 10 mg capsule, 30

8470T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.39	15.60	[a] APO-Ramipril [TX]	[a] Chem mart Ramipril [CH]
						[a] Ramace 10 mg [AV]	[a] Ramipril AN [EA]
						[a] Ramipril generichealth [GQ]	[a] Ramipril Sandoz [SZ]
						[a] Ramipril Winthrop [WA]	[a] Terry White Chemists Ramipril [TW]

						[a] Tritace 10 mg [SW] [a] Vascalace Caps 10 [DO]	[a] Tryzan Caps 10 [AF]

ramipril 10 mg tablet, 30

1316G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.39	15.60	[a] APO-Ramipril [TX] [a] Ramipril AN [EA] [a] Terry White Chemists Ramipril [TW] [a] Tryzan Tabs 10 [AF]	[a] Chem mart Ramipril [CH] [a] Ramipril Sandoz [SZ] [a] Tritace [SW] [a] Vascalace 10 [DO]

▪ RAMIPRIL

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

Note Pharmaceutical benefits that have the form ramipril 1.25 mg tablet and pharmaceutical benefits that have the form ramipril 1.25 mg capsule are equivalent for the purposes of substitution.

ramipril 1.25 mg capsule, 30

9120B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.11	13.32	[a] APO-Ramipril [TX] [a] Terry White Chemists Ramipril [TW] [a] Vascalace Caps 1.25 [DO]	[a] Chem mart Ramipril [CH] [a] Tryzan Caps 1.25 [AF]

ramipril 1.25 mg tablet, 30

1944H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.11	13.32	[a] Ramace 1.25 mg [AV] [a] Ramipril Winthrop [WA] [a] Tryzan Tabs 1.25 [AF]	[a] Ramipril Sandoz [SZ] [a] Tritace 1.25 mg [SW] [a] Vascalace 1.25 [DO]

▪ RAMIPRIL

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

Note Pharmaceutical benefits that have the form ramipril 2.5 mg tablet and pharmaceutical benefits that have the form ramipril 2.5 mg capsule are equivalent for the purposes of substitution.

ramipril 2.5 mg tablet, 30

1945J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.58	13.79	[a] APO-Ramipril [TX] [a] Ramace 2.5 mg [AV] [a] Ramipril Sandoz [SZ] [a] Terry White Chemists Ramipril [TW] [a] Tryzan Tabs 2.5 [AF]	[a] Chem mart Ramipril [CH] [a] Ramipril AN [EA] [a] Ramipril Winthrop [WA] [a] Tritace 2.5 mg [SW] [a] Vascalace 2.5 [DO]

ramipril 2.5 mg capsule, 30

9121C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.58	13.79	[a] APO-Ramipril [TX] [a] Ramipril generichealth [GQ] [a] Tryzan Caps 2.5 [AF]	[a] Chem mart Ramipril [CH] [a] Terry White Chemists Ramipril [TW] [a] Vascalace Caps 2.5 [DO]

▪ RAMIPRIL

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

Note Pharmaceutical benefits that have the form ramipril 5 mg tablet and pharmaceutical benefits that have the form ramipril 5 mg capsule are equivalent for the purposes of substitution.

ramipril 5 mg capsule, 30

9122D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.96	14.17	[a] APO-Ramipril [TX] [a] Ramipril generichealth [GQ] [a] Tryzan Caps 5 [AF]	[a] Chem mart Ramipril [CH] [a] Terry White Chemists Ramipril [TW] [a] Vascalace Caps 5 [DO]

ramipril 5 mg tablet, 30

1946K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.96	14.17	[a] APO-Ramipril [TX] [a] Ramace 5 mg [AV] [a] Ramipril Sandoz [SZ] [a] Terry White Chemists Ramipril [TW] [a] Tryzan Tabs 5 [AF]	[a] Chem mart Ramipril [CH] [a] Ramipril AN [EA] [a] Ramipril Winthrop [WA] [a] Tritace 5 mg [SW] [a] Vascalace 5 [DO]

▪ TRANDOLAPRIL

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

trandolapril 4 mg capsule, 28

8758Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.08	21.29	[a] Dolapril 4 [RW]	[a] Tranalpha [AF]
			[B]3.49	23.57	21.29	[a] Gopten [GO]	

trandolapril 500 microgram capsule, 28

2791X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.20	14.41	[a] Dolapril 0.5 [RW]	[a] Tranalpha [AF]
			[B]3.50	16.70	14.41	[a] Gopten [GO]	

trandolapril 2 mg capsule, 28

2793B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.87	17.08	[a] Dolapril 2 [RW]	[a] Tranalpha [AF]
			[B]3.50	19.37	17.08	[a] Gopten [GO]	

trandolapril 1 mg capsule, 28

2792Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.06	16.27	[a] Dolapril 1 [RW]	[a] Tranalpha [AF]
			[B]3.50	18.56	16.27	[a] Gopten [GO]	

ACE INHIBITORS, COMBINATIONS

ACE inhibitors and diuretics

▪ ENALAPRIL + HYDROCHLOROTHIAZIDE

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a thiazide diuretic.

enalapril maleate 20 mg + hydrochlorothiazide 6 mg tablet, 30

8477E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.46	17.67	[a] Enalapril/HCT Sandoz [SZ]
			[B]6.99	23.45	17.67	[a] Renitec Plus 20/6 [MK]

▪ FOSINOPRIL + HYDROCHLOROTHIAZIDE

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a thiazide diuretic.

fosinopril sodium 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

8401E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.49	20.70	[a] APO-Fosinopril HCTZ 20/12.5 [TX] [a] Fosinopril/HCT Actavis 20/12.5 [EA]	[a] Fosetic 20/12.5 [ZP]

▪ PERINDOPRIL + INDAPAMIDE

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

perindopril arginine 2.5 mg + indapamide hemihydrate 625 microgram tablet, 30

2190G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	13.07	14.28	[a] PREXUM Combi LD 2.5/0.625 [RW]
			[B]6.88	19.95	14.28	[a] Coversyl Plus LD 2.5mg/0.625mg [SE]

▪ PERINDOPRIL + INDAPAMIDE

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

Note Pharmaceutical benefits that have the form perindopril with indapamide hemihydrate tablet (containing 4 mg perindopril erbumine-1.25 mg indapamide hemihydrate) and pharmaceutical benefits that have the form perindopril with indapamide hemihydrate tablet (containing 5 mg perindopril arginine-1.25 mg indapamide hemihydrate) are equivalent for the purposes of substitution.

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a thiazide-like diuretic.

perindopril erbumine 4 mg + indapamide hemihydrate 1.25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8449Q NP	1	5	..	14.83	16.04	[a] Chem mart Perindopril/ Indapamide 4/1.25 [CH] [a] Idaprex Combi 4/1.25 [SZ] [a] Perindopril and Indapamide AN 4/1.25 [EF] [a] Perindopril/ Indapamide GH 4/1.25 [GQ]	[a] GenRx Perindopril/ Indapamide 4/1.25 [GX] [a] Indosyl Combi 4/1.25 [RW] [a] Perindopril Combi Actavis 4/1.25 [ED] [a] Terry White Chemists Perindopril/ Indapamide 4/1.25 [TW]
			[B]2.94	17.77	16.04	[a] Perindo Combi 4/1.25 [AF]	

perindopril arginine 5 mg + indapamide hemihydrate 1.25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2845R NP	1	5	..	14.83	16.04	[a] Prexum Combi 5/1.25 [RW]
			[B]6.13	20.96	16.04	[a] Coversyl Plus 5mg/1.25mg [SE]

▪ QUINAPRIL + HYDROCHLOROTHIAZIDE

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a thiazide diuretic.

quinapril 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8590D NP	1	5	..	17.85	19.06	Accuretic 20/12.5mg [PF]

quinapril 10 mg + hydrochlorothiazide 12.5 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8589C NP	1	5	..	16.92	18.13	Accuretic 10/12.5mg [PF]

ACE inhibitors and calcium channel blockers

▪ LERCANIDIPINE + ENALAPRIL

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

lercanidipine hydrochloride 10 mg + enalapril maleate 20 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9145H NP	1	5	..	16.85	18.06	Zan-Extra 10/20 [GO]

lercanidipine hydrochloride 10 mg + enalapril maleate 10 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9144G NP	1	5	..	16.07	17.28	Zan-Extra 10/10 [GO]

▪ PERINDOPRIL + AMLODIPINE

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

Restricted benefit

Stable coronary heart disease

Clinical criteria:

- The treatment must not be for the initiation of therapy for coronary heart disease, **AND**
- The condition must be stabilised by treatment with perindopril and amlodipine at the same doses.

perindopril arginine 10 mg + amlodipine 10 mg tablet, 30

9349C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.05	18.26	[a] APO-Perindopril Arginine/Amlodipine 10/10 [TX]	[a] Reaptan 10/10 [RW]
			[B]6.90	23.95	18.26	[a] Coveram 10/10 [SE]	

perindopril arginine 10 mg + amlodipine 5 mg tablet, 30

9348B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.36	17.57	[a] APO-Perindopril Arginine/Amlodipine 10/5 [TX]	[a] Reaptan 10/5 [RW]
			[B]6.59	22.95	17.57	[a] Coveram 10/5 [SE]	

perindopril arginine 5 mg + amlodipine 5 mg tablet, 30

9346X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.84	16.05	[a] APO-Perindopril Arginine/Amlodipine 5/5 [TX]	[a] Reaptan 5/5 [RW]
			[B]6.12	20.96	16.05	[a] Coveram 5/5 [SE]	

perindopril arginine 5 mg + amlodipine 10 mg tablet, 30

9347Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.53	16.74	[a] APO-Perindopril Arginine/Amlodipine 5/10 [TX]	[a] Reaptan 5/10 [RW]
			[B]6.43	21.96	16.74	[a] Coveram 5/10 [SE]	

▪ RAMIPRIL + FELODIPINE

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

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

ramipril 2.5 mg + felodipine 2.5 mg modified release tablet, 30

2626F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.39	16.60	Triasyn 2.5/2.5 [SW]

ramipril 5 mg + felodipine 5 mg modified release tablet, 30

2629J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.99	18.20	Triasyn 5.0/5.0 [SW]

▪ TRANDOLAPRIL + VERAPAMIL

Caution Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.
The myocardial depressant effects of verapamil hydrochloride and of beta-blocking drugs are additive.

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an ACE inhibitor; OR
- The condition must be inadequately controlled with verapamil.

trandolapril 2 mg + verapamil hydrochloride 180 mg modified release tablet, 28

9387C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	21.51	22.72	Tarka 2/180 [GO]

trandolapril 4 mg + verapamil hydrochloride 240 mg modified release tablet, 28

2857J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	27.58	28.79	Tarka 4/240 [GO]

ANGIOTENSIN II ANTAGONISTS, PLAIN

Angiotensin II antagonists, plain

▪ CANDESARTAN

candesartan cilexetil 4 mg tablet, 30

8295N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.55	12.76	[a] Adesan [AF]	[a] APO-Candesartan [TX]
						[a] Auro-Candesartan 4 [DO]	[a] Blooms the Chemist Candesartan [IB]
						[a] CANDESAN [RF]	[a] Candesartan AN [EA]
						[a] Candesartan Aspen 4 [RW]	[a] Candesartan Sandoz [SZ]
						[a] Chem mart Candesartan [CH]	[a] Terry White Chemists Candesartan [TW]
			[B]4.00	15.55	12.76	[a] Atacand [AP]	

candesartan cilexetil 16 mg tablet, 30

8297Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.22	16.43	[a] Adesan [AF]	[a] APO-Candesartan [TX]
						[a] Auro-Candesartan 16 [DO]	[a] Blooms the Chemist Candesartan [IB]
						[a] CANDESAN [RF]	[a] Candesartan AN [EA]
						[a] Candesartan Aspen 16 [RW]	[a] Candesartan GH [GQ]
						[a] Candesartan Sandoz [SZ]	[a] Chem mart Candesartan [CH]
						[a] Terry White Chemists Candesartan [TW]	
			[B]4.00	19.22	16.43	[a] Atacand [AP]	

candesartan cilexetil 8 mg tablet, 30

8296P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.48	13.69	[a] Adesan [AF]	[a] APO-Candesartan [TX]
						[a] Auro-Candesartan 8 [DO]	[a] Blooms the Chemist Candesartan [IB]
						[a] CANDESAN [RF]	[a] Candesartan AN [EA]
						[a] Candesartan Aspen 8 [RW]	[a] Candesartan Sandoz [SZ]
						[a] Chem mart Candesartan [CH]	[a] Terry White Chemists Candesartan [TW]
			[B]4.00	16.48	13.69	[a] Atacand [AP]	

candesartan cilexetil 32 mg tablet, 30

8889W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.08	17.29	[a] Adesan [AF]	[a] APO-Candesartan [TX]
						[a] Auro-Candesartan 32 [DO]	[a] Blooms the Chemist Candesartan [IB]
						[a] CANDESAN [RF]	[a] Candesartan AN [EA]
						[a] Candesartan Aspen 32 [RW]	[a] Candesartan GH [GQ]
						[a] Candesartan Sandoz [SZ]	[a] Chem mart Candesartan [CH]
						[a] Terry White Chemists Candesartan [TW]	
			[B]6.63	22.71	17.29	[a] Atacand [AP]	

▪ EPROSARTAN

eprosartan 600 mg tablet, 28

8447N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	[T]3.50	30.08	27.79	Teveten [GO]

eprosartan 400 mg tablet, 28

8397Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	[T]7.00	*30.45	24.66	Teveten [GO]

▪ EPROSARTAN

Authority required

Adverse effects occurring with all of the base-priced drugs

Authority required

Drug interactions occurring with all of the base-priced drugs
Authority required
Drug interactions expected to occur with all of the base-priced drugs
Authority required
Transfer to a base-priced drug would cause patient confusion resulting in problems with compliance

eprosartan 600 mg tablet, 28

5491B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	30.08	31.29	Teveten [GO]

eprosartan 400 mg tablet, 28

8951D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*30.45	31.66	Teveten [GO]

▪ IRBESARTAN

irbesartan 150 mg tablet, 30

8247C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.93	14.14	[a] Abisart [AF]	[a] APO-Irbesartan [TX]
						[a] Blooms the Chemist Irbesartan [IB]	[a] Chem mart Irbesartan [CH]
						[a] Irbesartan Actavis 150 [ED]	[a] Irbesartan AMNEAL [EF]
						[a] Irbesartan AN [EA]	[a] Irbesartan GH [GQ]
						[a] Irbesartan RBX [RA]	[a] Irbesartan Sandoz [SZ]
						[a] Irprestan 150 [ZP]	[a] Terry White Chemists Irbesartan [TW]
			[B]1.90	14.83	14.14	[a] Avapro [AV]	[a] Karvea [SW]

irbesartan 300 mg tablet, 30

8248D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.78	15.99	[a] Abisart [AF]	[a] APO-Irbesartan [TX]
						[a] Blooms the Chemist Irbesartan [IB]	[a] Chem mart Irbesartan [CH]
						[a] Irbesartan Actavis 300 [ED]	[a] Irbesartan AMNEAL [EF]
						[a] Irbesartan AN [EA]	[a] Irbesartan GH [GQ]
						[a] Irbesartan RBX [RA]	[a] Irbesartan Sandoz [SZ]
						[a] Irprestan 300 [ZP]	[a] Terry White Chemists Irbesartan [TW]
			[B]1.90	16.68	15.99	[a] Avapro [AV]	[a] Karvea [SW]

irbesartan 75 mg tablet, 30

8246B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.38	13.59	[a] Abisart [AF]	[a] APO-Irbesartan [TX]
						[a] Blooms the Chemist Irbesartan [IB]	[a] Chem mart Irbesartan [CH]
						[a] Irbesartan Actavis 75 [ED]	[a] Irbesartan AMNEAL [EF]
						[a] Irbesartan AN [EA]	[a] Irbesartan GH [GQ]
						[a] Irbesartan Sandoz [SZ]	[a] Irprestan 75 [ZP]
						[a] Terry White Chemists Irbesartan [TW]	
			[B]1.90	14.28	13.59	[a] Avapro [AV]	[a] Karvea [SW]

▪ LOSARTAN

losartan potassium 25 mg tablet, 30

5452Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.56	17.77	Cozavan [AF]

losartan potassium 50 mg tablet, 30

8203R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*26.73	27.94	Cozavan [AF]

▪ OLMESARTAN MEDOXOMIL

olmesartan medoxomil 40 mg tablet, 30

2148C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.04	29.25	[a] APO-Olmesartan [TX]	[a] OLMERTAN [RW]
						[a] Olmesartan AN [EA]	[a] Olmesartan - MYL [AF]
						[a] Olmesartan Sandoz [SZ]	[a] Pharmacor Olmesartan 40 [CR]

			[B]3.50	31.54	29.25	[a] Olmetec [MK]	

olmesartan medoxomil 20 mg tablet, 30

2147B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.08	20.29	[a] APO-Olmesartan [TX] [a] Olmesartan AN [EA] [a] Olmesartan Sandoz [SZ]	[a] OLMERTAN [RW] [a] Olmesartan - MYL [AF] [a] Pharmacor Olmesartan 20 [CR]
			[B]3.50	22.58	20.29	[a] Olmetec [MK]	

▪ TELMISARTAN

telmisartan 40 mg tablet, 28

8355R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.18	14.39	[a] APO-Telmisartan [TX] [a] Pharmacor Telmisartan 40 [CR] [a] Telmisartan-DRLA [RZ] [a] Telmisartan Sandoz [SZ]	[a] Mizart [AF] [a] Telmisartan AN [EA] [a] Telmisartan GH [GQ] [a] Teltartan [RW]
			[B]2.68	15.86	14.39	[a] Micardis [BY]	

telmisartan 80 mg tablet, 28

8356T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.12	18.33	[a] APO-Telmisartan [TX] [a] Pharmacor Telmisartan 80 [CR] [a] Telmisartan-DRLA [RZ] [a] Telmisartan Sandoz [SZ]	[a] Mizart [AF] [a] Telmisartan AN [EA] [a] Telmisartan GH [GQ] [a] Teltartan [RW]
			[B]2.69	19.81	18.33	[a] Micardis [BY]	

▪ VALSARTAN

valsartan 80 mg tablet, 28

9369D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.99	21.20	[a] APO-Valsartan [TX] [a] Diovan [NV]	[a] Dilart [AF]

valsartan 40 mg tablet, 28

9368C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	17.20	18.41	[a] APO-Valsartan [TX] [a] Diovan [NV]	[a] Dilart [AF]

valsartan 160 mg tablet, 28

9370E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.52	23.73	[a] APO-Valsartan [TX] [a] Diovan [NV]	[a] Dilart [AF]

▪ VALSARTAN

Note No applications for increased maximum quantities and/or repeats will be authorised for the 320 mg tablet.

valsartan 320 mg tablet, 28

9371F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.74	26.95	[a] APO-Valsartan [TX] [a] Diovan [NV]	[a] Dilart [AF]

ANGIOTENSIN II ANTAGONISTS, COMBINATIONS

Angiotensin II antagonists and diuretics

▪ CANDESARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

candesartan cilexetil 16 mg + hydrochlorothiazide 12.5 mg tablet, 30

8504N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.52	16.73	[a] Adesan HCT 16/12.5 [AF]	[a] APO-Candesartan HCTZ 16/12.5 [TX]

						[a] Asartan HCT 16/12.5 [DO]	[a] Blooms the Chemist Candesartan HCTZ 16/12.5 [IB]
						[a] CANDESAN COMBI 16/12.5 [RF]	[a] Candesartan Combi Aspen 16/12.5 [RW]
						[a] Candesartan HCT GH 16/12.5 [GQ]	[a] Candesartan/HCT Sandoz [SZ]
						[a] Candesartan HCTZ AN 16/12.5 [EA]	[a] Chem mart Candesartan HCTZ 16/12.5 [CH]
						[a] Terry White Chemists Candesartan HCTZ 16/12.5 [TW]	
			[B]4.00	19.52	16.73	[a] Atacand Plus 16/12.5 [AP]	

candesartan cilexetil 32 mg + hydrochlorothiazide 12.5 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9314F NP	1	5	..	16.27	17.48	[a] Adesan HCT 32/12.5 [AF]	[a] APO-Candesartan HCTZ 32/12.5 [TX]
						[a] Asartan HCT 32/12.5 [DO]	[a] Blooms the Chemist Candesartan HCTZ 32/12.5 [IB]
						[a] CANDESAN COMBI 32/12.5 [RF]	[a] Candesartan Combi Aspen 32/12.5 [RW]
						[a] Candesartan HCT GH 32/12.5 [GQ]	[a] Candesartan/HCT Sandoz [SZ]
						[a] Candesartan HCTZ AN 32/12.5 [EA]	[a] Chem mart Candesartan HCTZ 32/12.5 [CH]
						[a] Terry White Chemists Candesartan HCTZ 32/12.5 [TW]	
			[B]9.25	25.52	17.48	[a] Atacand Plus 32/12.5 [AP]	

candesartan cilexetil 32 mg + hydrochlorothiazide 25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9315G NP	1	5	..	17.10	18.31	[a] Adesan HCT 32/25 [AF]	[a] APO-Candesartan HCTZ 32/25 [TX]
						[a] Asartan HCT 32/25 [DO]	[a] Blooms the Chemist Candesartan HCTZ 32/25 [IB]
						[a] CANDESAN COMBI 32/25 [RF]	[a] Candesartan Combi Aspen 32/25 [RW]
						[a] Candesartan HCT GH 32/25 [GQ]	[a] Candesartan/HCT Sandoz [SZ]
						[a] Candesartan HCTZ AN 32/25 [EA]	[a] Chem mart Candesartan HCTZ 32/25 [CH]
						[a] Terry White Chemists Candesartan HCTZ 32/25 [TW]	
			[B]7.75	24.85	18.31	[a] Atacand Plus 32/25 [AP]	

▪ EPROSARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

eprosartan 600 mg + hydrochlorothiazide 12.5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8624X NP	1	5	..	28.30	29.51	Teveten Plus 600/12.5 [GO]

▪ IRBESARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

irbesartan 300 mg + hydrochlorothiazide 25 mg tablet, 30

2136K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.30	16.51	[a] Abisart HCT 300/25 [AF] [a] Blooms the Chemist Irbesartan HCTZ 300/25 [IB] [a] Irbesartan HCT Actavis 300/25 [ED] [a] Irbesartan/HCT Sandoz [SZ] [a] Irbesartan/HCTZ RBX 300/25 [RA] [a] Terry White Chemists Irbesartan HCTZ [TW]	[a] APO-Irbesartan HCTZ [TX] [a] Chem mart Irbesartan HCTZ [CH] [a] Irbesartan HCT GH 300/25 [GQ] [a] Irbesartan HCTZ AMNEAL [EF] [a] KSART HCT 300/25 [RW]
			[B]1.90	17.20	16.51	[a] Avapro HCT 300/25 [AV]	[a] Karvezide 300/25 [SW]

irbesartan 300 mg + hydrochlorothiazide 12.5 mg tablet, 30

8405J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.96	16.17	[a] Abisart HCT 300/12.5 [AF] [a] Blooms the Chemist Irbesartan HCTZ 300/12.5 [IB] [a] Irbesartan HCT Actavis 300/12.5 [ED] [a] Irbesartan/HCT Sandoz [SZ] [a] KSART HCT 300/12.5 [RW]	[a] APO-Irbesartan HCTZ [TX] [a] Chem mart Irbesartan HCTZ [CH] [a] Irbesartan HCT GH 300/12.5 [GQ] [a] Irbesartan HCTZ AMNEAL [EF] [a] Terry White Chemists Irbesartan HCTZ [TW]
			[B]1.90	16.86	16.17	[a] Avapro HCT 300/12.5 [AV]	[a] Karvezide 300/12.5 [SW]

irbesartan 150 mg + hydrochlorothiazide 12.5 mg tablet, 30

8404H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.20	14.41	[a] Abisart HCT 150/12.5 [AF] [a] Blooms the Chemist Irbesartan HCTZ 150/12.5 [IB] [a] Irbesartan HCT Actavis 150/12.5 [ED] [a] Irbesartan/HCT Sandoz [SZ] [a] Irbesartan/HCTZ RBX 150/12.5 [RA] [a] Terry White Chemists Irbesartan HCTZ [TW]	[a] APO-Irbesartan HCTZ [TX] [a] Chem mart Irbesartan HCTZ [CH] [a] Irbesartan HCT GH 150/12.5 [GQ] [a] Irbesartan HCTZ AMNEAL [EF] [a] KSART HCT 150/12.5 [RW]
			[B]1.90	15.10	14.41	[a] Avapro HCT 150/12.5 [AV]	[a] Karvezide 150/12.5 [SW]

▪ OLMESARTAN MEDOXOMIL + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

olmesartan medoxomil 40 mg + hydrochlorothiazide 12.5 mg tablet, 30

2166B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	29.58	30.79	[a] APO-Olmesartan/HCTZ 40/12.5 [TX] [a] Olmesartan HCT AN 40/12.5 [EA] [a] Olmesartan/HCT Sandoz [SZ]	[a] OLMERTAN COMBI 40/12.5 [RW] [a] Olmesartan HCT - MYL 40/12.5 [AF] [a] Olmetec Plus [MK]

olmesartan medoxomil 40 mg + hydrochlorothiazide 25 mg tablet, 30

2170F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	31.12	32.33	[a] APO-Olmesartan/HCTZ 40/25 [TX] [a] Olmesartan HCT AN 40/25 [EA] [a] Olmesartan/HCT Sandoz [SZ]	[a] OLMERTAN COMBI 40/25 [RW] [a] Olmesartan HCT - MYL 40/25 [AF] [a] Olmetec Plus [MK]

olmesartan medoxomil 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

2161R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.63	21.84	[a] APO-Olmesartan/HCTZ 20/12.5 [TX]	[a] OLMERTAN COMBI 20/12.5 [RW]

						[a] Olmesartan HCT AN 20/12.5 [EA]	[a] Olmesartan HCT - MYL 20/12.5 [AF]
						[a] Olmesartan/HCT Sandoz [SZ]	[a] Olmetec Plus [MK]

▪ TELMISARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

telmisartan 40 mg + hydrochlorothiazide 12.5 mg tablet, 28

8622T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.37	14.58	[a] APO-Telmisartan HCTZ 40/12.5 [TX]	[a] Mizart HCT 40/12.5 mg [AF]
						[a] Pritor Plus 40/12.5 mg [FI]	[a] Telmisartan HCT GH 40/12.5 [GQ]
						[a] Telmisartan/HCT Sandoz [SZ]	[a] Telmisartan HCTZ AN 40/12.5 [EA]
						[a] Teltartan HCT 40/12.5 [RW]	
			[B]2.69	16.06	14.58	[a] Micardis Plus 40/12.5 mg [BY]	

telmisartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28

8623W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.78	17.99	[a] APO-Telmisartan HCTZ 80/12.5 [TX]	[a] Mizart HCT 80/12.5 mg [AF]
						[a] Pritor Plus 80/12.5 mg [FI]	[a] Telmisartan HCT GH 80/12.5 [GQ]
						[a] Telmisartan/HCT Sandoz [SZ]	[a] Telmisartan HCTZ AN 80/12.5 [EA]
						[a] Teltartan HCT 80/12.5 [RW]	
			[B]2.69	19.47	17.99	[a] Micardis Plus 80/12.5 mg [BY]	

telmisartan 80 mg + hydrochlorothiazide 25 mg tablet, 28

9381R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.28	18.49	[a] APO-Telmisartan HCTZ 80/25 [TX]	[a] Mizart HCT 80/25 mg [AF]
						[a] Pritor Plus 80/25 mg [FI]	[a] Telmisartan HCT GH 80/25 [GQ]
						[a] Telmisartan/HCT Sandoz [SZ]	[a] Telmisartan HCTZ AN 80/25 [EA]
						[a] Teltartan HCT 80/25 [RW]	
			[B]2.69	19.97	18.49	[a] Micardis Plus 80/25 mg [BY]	

▪ VALSARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

valsartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28

9372G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.51	22.72	[a] APO-Valsartan HCTZ 80/12.5 [TX]	[a] Co-Diovan 80/12.5 [NV]
						[a] Dilart HCT 80/12.5 [AF]	

valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

9374J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.55	26.76	[a] APO-Valsartan HCTZ 160/25 [TX]	[a] Co-Diovan 160/25 [NV]
						[a] Dilart HCT 160/25 [AF]	

valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

9373H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	24.04	25.25	[a] APO-Valsartan HCTZ 160/12.5 [TX]	[a] Co-Diovan 160/12.5 [NV]
						[a] Dilart HCT 160/12.5 [AF]	

▪ VALSARTAN + HYDROCHLOROTHIAZIDE

Note No applications for increased maximum quantities and/or repeats will be authorised for the tablets containing 320 mg valsartan.

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a thiazide diuretic.

valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

9482C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.78	29.99	[a] APO-Valsartan HCTZ 320/25 [TX] [a] Dilart HCT 320/25 [AF]	[a] Co-Diovan 320/25 [NV]

valsartan 320 mg + hydrochlorothiazide 12.5 mg tablet, 28

9481B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.26	28.47	[a] APO-Valsartan HCTZ 320/12.5 [TX] [a] Dilart HCT 320/12.5 [AF]	[a] Co-Diovan 320/12.5 [NV]

Angiotensin II antagonists and calcium channel blockers

▪ AMLODIPINE + VALSARTAN

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

amlodipine 5 mg + valsartan 320 mg tablet, 28

5459H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	26.57	27.78	Exforge 5/320 [NV]

amlodipine 5 mg + valsartan 80 mg tablet, 28

9375K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.82	22.03	[a] Exforge 5/80 [NV]	[a] Valsartan/Amlodipine Sandoz 80/5 [NM]

amlodipine 10 mg + valsartan 160 mg tablet, 28

9377M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	23.99	25.20	Exforge 10/160 [NV]

amlodipine 5 mg + valsartan 160 mg tablet, 28

9376L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	23.35	24.56	Exforge 5/160 [NV]

amlodipine 10 mg + valsartan 320 mg tablet, 28

5460J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	27.22	28.43	Exforge 10/320 [NV]

▪ OLMESARTAN MEDOXOMIL + AMLODIPINE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

olmesartan medoxomil 20 mg + amlodipine 5 mg tablet, 30

5292M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.97	21.18	[a] APO-Olmesartan/Amlodipine 20/5 [TX] [a] Sevikar 20/5 [MK]	[a] Olmesartan/Amlodipine - MYL 20/5 [AF]

olmesartan medoxomil 40 mg + amlodipine 10 mg tablet, 30

5294P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	29.62	30.83	[a] APO-Olmesartan/Amlodipine 40/10 [TX] [a] Sevikar 40/10 [MK]	[a] Olmesartan/Amlodipine - MYL 40/10 [AF]

olmesartan medoxomil 40 mg + amlodipine 5 mg tablet, 30

5293N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.93	30.14	[a] APO-Olmesartan/Amlodipine 40/5 [TX] [a] Sevikar 40/5 [MK]	[a] Olmesartan/Amlodipine - MYL 40/5 [AF]

▪ TELMISARTAN + AMLODIPINE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with an angiotensin II antagonist; OR
- The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

telmisartan 40 mg + amlodipine 10 mg tablet, 28

8979N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.65	15.86	[a] Pritor/Amlodipine [FI]
			[B]2.69	17.34	15.86	[a] Twynsta [BY]

telmisartan 80 mg + amlodipine 5 mg tablet, 28

8980P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.95	19.16	[a] Pritor/Amlodipine [FI]
			[B]2.69	20.64	19.16	[a] Twynsta [BY]

telmisartan 40 mg + amlodipine 5 mg tablet, 28

8978M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.00	15.21	[a] Pritor/Amlodipine [FI]
			[B]2.69	16.69	15.21	[a] Twynsta [BY]

telmisartan 80 mg + amlodipine 10 mg tablet, 28

8981Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.59	19.80	[a] Pritor/Amlodipine [FI]
			[B]2.69	21.28	19.80	[a] Twynsta [BY]

Angiotensin II antagonists, other combinations

▪ AMLODIPINE + VALSARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with concomitant treatment with two of the following: an angiotensin II antagonist, a dihydropyridine calcium channel blocker or a thiazide diuretic.

amlodipine 10 mg + valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

5289J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	30.25	31.46	Exforge HCT 10/320/25 [NV]

amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

5286F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	26.38	27.59	Exforge HCT 5/160/25 [NV]

amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

5287G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	25.51	26.72	Exforge HCT 10/160/12.5 [NV]

amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

5285E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	24.86	26.07	[a] Exforge HCT 5/160/12.5 [NV]	[a] Valsartan/Amlodipine/HCT Sandoz 160/5/12.5 [NM]

amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

5288H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	27.02	28.23	Exforge HCT 10/160/25 [NV]

▪ OLMESARTAN + AMLODIPINE + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

- The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
- The condition must be inadequately controlled with concomitant treatment with two of the following: an angiotensin II antagonist, a dihydropyridine calcium channel blocker or a thiazide diuretic.

olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 25 mg tablet, 30

2864R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	32.60	33.81	Sevikar HCT 40/5/25 [MK]

olmesartan medoxomil 20 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30

10005N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	21.81	23.02	Sevikar HCT 20/5/12.5 [MK]

olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 25 mg tablet, 30

2953K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	33.29	34.50	Sevikar HCT 40/10/25 [MK]

olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 12.5 mg tablet, 30

2836G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	31.45	32.66	Sevikar HCT 40/10/12.5 [MK]

olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30

2880N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	30.77	31.98	Sevikar HCT 40/5/12.5 [MK]

▪ SACUBITRIL + VALSARTAN

Note Continuing Therapy Only:

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6915

Chronic heart failure

Clinical criteria:

- Patient must be symptomatic with NYHA classes II, III or IV, **AND**
- Patient must have a documented left ventricular ejection fraction (LVEF) of less than or equal to 40%, **AND**
- Patient must receive concomitant optimal standard chronic heart failure treatment, which must include the maximum tolerated dose of a beta-blocker, unless contraindicated or not tolerated, **AND**
- Patient must have been stabilised on an ACE inhibitor at the time of initiation with this drug, unless such treatment is contraindicated according to the TGA-approved Product Information or cannot be tolerated; OR
- Patient must have been stabilised on an angiotensin II antagonist at the time of initiation with this drug, unless such treatment is contraindicated according to the TGA-approved Product Information or cannot be tolerated, **AND**
- The treatment must not be co-administered with an ACE inhibitor or an angiotensin II antagonist.

sacubitril 97.2 mg + valsartan 102.8 mg tablet, 56

11122J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	202.22	39.50	Entresto [NV]

sacubitril 24.3 mg + valsartan 25.7 mg tablet, 56

11123K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	202.22	39.50	Entresto [NV]

sacubitril 48.6 mg + valsartan 51.4 mg tablet, 56

11131W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	202.22	39.50	Entresto [NV]

▪ LIPID MODIFYING AGENTS

LIPID MODIFYING AGENTS, PLAIN

HMG CoA reductase inhibitors

▪ ATORVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

atorvastatin 80 mg tablet, 30

8521L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.63	16.84	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 80 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 80 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 80 [RW]	[a] Trovas [RA]

atorvastatin 10 mg tablet, 30

8213G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.62	13.83	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 10 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 10 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 10 [RW]	[a] Trovas [RA]

atorvastatin 40 mg tablet, 30

8215J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.26	15.47	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 40 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 40 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 40 [RW]	[a] Trovas [RA]

atorvastatin 20 mg tablet, 30

8214H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.35	14.56	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 20 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 20 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 20 [RW]	[a] Trovas [RA]

▪ ATORVASTATIN

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

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

atorvastatin 80 mg tablet, 30

9233Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	15.63	16.84	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]

						[a] Atorvastatin SCP 80 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 80 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 80 [RW]	[a] Trovas [RA]

atorvastatin 10 mg tablet, 30

9230T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	12.62	13.83	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 10 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 10 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 10 [RW]	[a] Trovas [RA]

atorvastatin 40 mg tablet, 30

9232X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	14.26	15.47	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 40 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 40 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 40 [RW]	[a] Trovas [RA]

atorvastatin 20 mg tablet, 30

9231W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	13.35	14.56	[a] APO-Atorvastatin [TX]	[a] Atorvastatin Amneal [EF]
						[a] Atorvastatin GH [GQ]	[a] Atorvastatin Sandoz [SZ]
						[a] Atorvastatin SCP 20 [RZ]	[a] Atorvastatin SZ [HX]
						[a] Blooms the Chemist Atorvastatin [IB]	[a] Chem mart Atorvastatin [CH]
						[a] Lipitor [PF]	[a] Lorstat 20 [AF]
						[a] Pharmacor Atorvastatin [CR]	[a] Terry White Chemists Atorvastatin [TW]
						[a] Torvastat 20 [RW]	[a] Trovas [RA]

▪ FLUVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

fluvastatin 80 mg modified release tablet, 28

2863Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	45.59	39.50	Lescol XL [NV]

▪ FLUVASTATIN

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

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

fluvastatin 80 mg modified release tablet, 28

9236D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	11	..	45.59	39.50	Lescol XL [NV]

▪ PRAVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

pravastatin sodium 10 mg tablet, 30

2833D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.63	13.84	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 10 [DO] [a] Lipostat 10 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]2.94	15.57	13.84	[a] Pravachol [RW]	
			[B]2.95	15.58	13.84	[a] Cholstat 10 [AF]	

pravastatin sodium 20 mg tablet, 30

2834E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.53	14.74	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Cholvastin [RA] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 20 [DO] [a] Cholstat 20 [AF] [a] Lipostat 20 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]2.96	16.49	14.74	[a] Pravachol [RW]	

pravastatin sodium 40 mg tablet, 30

8197K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.89	16.10	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Cholvastin [RA] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 40 [DO] [a] Cholstat 40 [AF] [a] Lipostat 40 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]3.01	17.90	16.10	[a] Pravachol [RW]	

pravastatin sodium 80 mg tablet, 30

8829Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.93	18.14	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 80 [DO] [a] Lipostat 80 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]3.01	19.94	18.14	[a] Pravachol [RW]	

▪ PRAVASTATIN

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

pravastatin sodium 10 mg tablet, 30

9237E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	12.63	13.84	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 10 [DO] [a] Lipostat 10 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]2.94	15.57	13.84	[a] Pravachol [RW]	
			[B]2.95	15.58	13.84	[a] Cholstat 10 [AF]	

pravastatin sodium 20 mg tablet, 30

9238F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	13.53	14.74	[a] APO-Pravastatin [TX] [a] Chem mart Pravastatin [CH] [a] Cholvastin [RA] [a] Pravastatin AN [EA] [a] Pravastatin Sandoz [SZ]	[a] Auro-Pravastatin 20 [DO] [a] Cholstat 20 [AF] [a] Lipostat 20 [RF] [a] Pravastatin generichealth [GQ] [a] Terry White Chemists Pravastatin [TW]
			[B]2.96	16.49	14.74	[a] Pravachol [RW]	

pravastatin sodium 40 mg tablet, 30

9239G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	14.89	16.10	[a] APO-Pravastatin [TX]	[a] Auro-Pravastatin 40 [DO]
						[a] Chem mart Pravastatin [CH]	[a] Cholstat 40 [AF]
						[a] Cholvastin [RA]	[a] Lipostat 40 [RF]
						[a] Pravastatin AN [EA]	[a] Pravastatin generichealth [GQ]
						[a] Pravastatin Sandoz [SZ]	[a] Terry White Chemists Pravastatin [TW]
			[B]3.01	17.90	16.10	[a] Pravachol [RW]	

pravastatin sodium 80 mg tablet, 30

9240H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	16.93	18.14	[a] APO-Pravastatin [TX]	[a] Auro-Pravastatin 80 [DO]
						[a] Chem mart Pravastatin [CH]	[a] Lipostat 80 [RF]
						[a] Pravastatin AN [EA]	[a] Pravastatin generichealth [GQ]
						[a] Pravastatin Sandoz [SZ]	[a] Terry White Chemists Pravastatin [TW]
			[B]3.01	19.94	18.14	[a] Pravachol [RW]	

▪ ROSUVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

rosuvastatin 5 mg tablet, 30

2606E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.85	16.06	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 5 [ZP]
						[a] Pharmacor Rosuvastatin 5 [CR]	[a] Rosuvastatin AMNEAL [EF]
						[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
						[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

2594M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.30	23.51	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 40 [ZP]
						[a] Pharmacor Rosuvastatin 40 [CR]	[a] Rosuvastatin AMNEAL [EF]
						[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
						[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 20 mg tablet, 30

2574L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.95	20.16	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 20 [ZP]
						[a] Pharmacor Rosuvastatin 20 [CR]	[a] Rosuvastatin AMNEAL [EF]
						[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
						[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 10 mg tablet, 30

2628H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.62	17.83	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 10 [ZP]
						[a] Pharmacor Rosuvastatin 10 [CR]	[a] Rosuvastatin AMNEAL [EF]

					[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
					[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

▪ ROSUVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- The treatment must not be prescribed for hypercholesterolaemia if the patient has heterozygous familial hypercholesterolaemia.

rosuvastatin 5 mg tablet, 30

9042X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.85	16.06	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 5 [ZP]
						[a] Pharmacor Rosuvastatin 5 [CR]	[a] Rostor 5 [DO]
						[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
						[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
						[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
						[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 40 mg tablet, 30

9045C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.30	23.51	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 40 [ZP]
						[a] Pharmacor Rosuvastatin 40 [CR]	[a] Rostor 40 [DO]
						[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
						[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
						[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
						[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 20 mg tablet, 30

9044B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.95	20.16	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 20 [ZP]
						[a] Pharmacor Rosuvastatin 20 [CR]	[a] Rostor 20 [DO]
						[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
						[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
						[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
						[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 10 mg tablet, 30

9043Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.62	17.83	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
						[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
						[a] Crestor [AP]	[a] Crosuva 10 [ZP]
						[a] Pharmacor Rosuvastatin 10 [CR]	[a] Rostor 10 [DO]
						[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
						[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
						[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
						[a] Terry White Chemists Rosuvastatin [TW]	

▪ ROSUVASTATIN

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

rosuvastatin 5 mg tablet, 30

2590H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	14.85	16.06	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 5 [ZP]
					[a] Pharmacor Rosuvastatin 5 [CR]	[a] Rosuvastatin AMNEAL [EF]
					[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
					[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

2636R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	22.30	23.51	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 40 [ZP]
					[a] Pharmacor Rosuvastatin 40 [CR]	[a] Rosuvastatin AMNEAL [EF]
					[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
					[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 20 mg tablet, 30

2609H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	18.95	20.16	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 20 [ZP]
					[a] Pharmacor Rosuvastatin 20 [CR]	[a] Rosuvastatin AMNEAL [EF]
					[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
					[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

rosuvastatin 10 mg tablet, 30

2584B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	16.62	17.83	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 10 [ZP]
					[a] Pharmacor Rosuvastatin 10 [CR]	[a] Rosuvastatin AMNEAL [EF]
					[a] Rosuvastatin-DRLA [RI]	[a] Rosuvastatin generichealth [HQ]
					[a] Rosuvastatin GH [GQ]	[a] Terry White Chemists Rosuvastatin [TW]

▪ ROSUVASTATIN

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements, **AND**

- The treatment must not be prescribed for hypercholesterolaemia if the patient has heterozygous familial hypercholesterolaemia.

rosuvastatin 5 mg tablet, 30

3402C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	14.85	16.06	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 5 [ZP]
					[a] Pharmacor Rosuvastatin 5 [CR]	[a] Rostor 5 [DO]
					[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
					[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
					[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
					[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 40 mg tablet, 30

3405F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	22.30	23.51	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 40 [ZP]
					[a] Pharmacor Rosuvastatin 40 [CR]	[a] Rostor 40 [DO]
					[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
					[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
					[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
					[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 20 mg tablet, 30

3404E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	18.95	20.16	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 20 [ZP]
					[a] Pharmacor Rosuvastatin 20 [CR]	[a] Rostor 20 [DO]
					[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
					[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
					[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
					[a] Terry White Chemists Rosuvastatin [TW]	

rosuvastatin 10 mg tablet, 30

3403D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	16.62	17.83	[a] APO-Rosuvastatin [TX]	[a] Blooms the Chemist Rosuvastatin [IB]
					[a] Cavstat [AF]	[a] Chem mart Rosuvastatin [CH]
					[a] Crestor [AP]	[a] Crosuva 10 [ZP]
					[a] Pharmacor Rosuvastatin 10 [CR]	[a] Rostor 10 [DO]
					[a] Rosuvastatin AMNEAL [EF]	[a] Rosuvastatin-DRLA [RI]
					[a] Rosuvastatin generichealth [HQ]	[a] Rosuvastatin GH [GQ]
					[a] Rosuvastatin RBX [RA]	[a] Rosuvastatin Sandoz [SZ]
					[a] Terry White Chemists Rosuvastatin [TW]	

▪ SIMVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

simvastatin 80 mg tablet, 30

8313M

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	14.42	15.63	[a] APO-Simvastatin [TX]	[a] Auro-Simvastatin 80 [DO]
					[a] Chem mart Simvastatin [CH]	[a] Ransim [RA]
					[a] Simvacor 80 [CR]	[a] Simvar 80 [RW]

						[a] Simvastatin AN [EA]	[a] Simvastatin generichealth [GQ]
						[a] Simvastatin Sandoz [SZ]	[a] Terry White Chemists Simvastatin [TW]
						[a] Zimstat [AF]	
			[B]8.46	22.88	15.63	[a] Lipex 80 [FR]	[a] Zocor [MK]

simvastatin 10 mg tablet, 30

2011W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.21	13.42	[a] APO-Simvastatin [TX]	[a] Auro-Simvastatin 10 [DO]
						[a] Chem mart Simvastatin [CH]	[a] Ransim [RA]
						[a] Simvacor 10 [CR]	[a] Simvar 10 [RW]
						[a] Simvastatin AN [EA]	[a] Simvastatin generichealth [GQ]
						[a] Simvastatin Sandoz [SZ]	[a] Terry White Chemists Simvastatin [TW]
						[a] Zimstat [AF]	
			[B]5.33	17.54	13.42	[a] Lipex 10 [FR]	[a] Zocor [MK]

simvastatin 20 mg tablet, 30

2012X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.71	13.92	[a] APO-Simvastatin [TX]	[a] Auro-Simvastatin 20 [DO]
						[a] Chem mart Simvastatin [CH]	[a] Ransim [RA]
						[a] Simvacor 20 [CR]	[a] Simvar 20 [RW]
						[a] Simvastatin AN [EA]	[a] Simvastatin generichealth [GQ]
						[a] Simvastatin Sandoz [SZ]	[a] Terry White Chemists Simvastatin [TW]
						[a] Zimstat [AF]	
			[B]7.50	20.21	13.92	[a] Lipex 20 [FR]	[a] Zocor [MK]

simvastatin 5 mg tablet, 30

2013Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.91	13.12	[a] Simvastatin Sandoz [SZ]	[a] Zimstat [AF]

simvastatin 40 mg tablet, 30

8173E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.42	14.63	[a] APO-Simvastatin [TX]	[a] Auro-Simvastatin 40 [DO]
						[a] Chem mart Simvastatin [CH]	[a] Ransim [RA]
						[a] Simvacor 40 [CR]	[a] Simvar 40 [RW]
						[a] Simvastatin AN [EA]	[a] Simvastatin generichealth [GQ]
						[a] Simvastatin Sandoz [SZ]	[a] Terry White Chemists Simvastatin [TW]
						[a] Zimstat [AF]	
			[B]7.50	20.92	14.63	[a] Lipex 40 [FR]	[a] Zocor [MK]

▪ SIMVASTATIN

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

simvastatin 80 mg tablet, 30

9245N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	14.42	15.63	[a] APO-Simvastatin [TX]	[a] Auro-Simvastatin 80 [DO]
						[a] Chem mart Simvastatin [CH]	[a] Ransim [RA]
						[a] Simvacor 80 [CR]	[a] Simvar 80 [RW]
						[a] Simvastatin AN [EA]	[a] Simvastatin generichealth [GQ]
						[a] Simvastatin Sandoz [SZ]	[a] Terry White Chemists Simvastatin [TW]
						[a] Zimstat [AF]	
			[B]8.46	22.88	15.63	[a] Lipex 80 [FR]	[a] Zocor [MK]

simvastatin 10 mg tablet, 30

9242K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	12.21	13.42	[a] APO-Simvastatin [TX] [a] Chem mart Simvastatin [CH] [a] Simvacor 10 [CR] [a] Simvastatin AN [EA] [a] Simvastatin Sandoz [SZ] [a] Zimstat [AF]	[a] Auro-Simvastatin 10 [DO] [a] Ransim [RA] [a] Simvar 10 [RW] [a] Simvastatin generichealth [GQ] [a] Terry White Chemists Simvastatin [TW]
			[B]5.33	17.54	13.42	[a] Lipex 10 [FR]	[a] Zocor [MK]

simvastatin 20 mg tablet, 30

9243L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	12.71	13.92	[a] APO-Simvastatin [TX] [a] Chem mart Simvastatin [CH] [a] Simvacor 20 [CR] [a] Simvastatin AN [EA] [a] Simvastatin Sandoz [SZ] [a] Zimstat [AF]	[a] Auro-Simvastatin 20 [DO] [a] Ransim [RA] [a] Simvar 20 [RW] [a] Simvastatin generichealth [GQ] [a] Terry White Chemists Simvastatin [TW]
			[B]7.50	20.21	13.92	[a] Lipex 20 [FR]	[a] Zocor [MK]

simvastatin 5 mg tablet, 30

9241J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	11.91	13.12	[a] Simvastatin Sandoz [SZ]	[a] Zimstat [AF]

simvastatin 40 mg tablet, 30

9244M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	13.42	14.63	[a] APO-Simvastatin [TX] [a] Chem mart Simvastatin [CH] [a] Simvacor 40 [CR] [a] Simvastatin AN [EA] [a] Simvastatin Sandoz [SZ] [a] Zimstat [AF]	[a] Auro-Simvastatin 40 [DO] [a] Ransim [RA] [a] Simvar 40 [RW] [a] Simvastatin generichealth [GQ] [a] Terry White Chemists Simvastatin [TW]
			[B]7.50	20.92	14.63	[a] Lipex 40 [FR]	[a] Zocor [MK]

Fibrates

▪ FENOFIBRATE

Note The risk of serious muscle toxicity is increased if this drug is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

fenofibrate 48 mg tablet, 60

9022W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	30.60	31.81	Lipidil [GO]

fenofibrate 145 mg tablet, 30

9023X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	40.38	39.50	Lipidil [GO]

▪ FENOFIBRATE

Note The risk of serious muscle toxicity is increased if this drug is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

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

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

fenofibrate 48 mg tablet, 60

9246P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	11	..	30.60	31.81	Lipidil [GO]

fenofibrate 145 mg tablet, 30

9247Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	11	..	40.38	39.50	Lipidil [GO]

▪ GEMFIBROZIL

Note The risk of serious muscle toxicity is increased if this drug is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

gemfibrozil 600 mg tablet, 60

1453L

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	20.99	22.20	[a] Ausgem [RW]	[a] Lipigem [AF]

▪ GEMFIBROZIL

Note The risk of serious muscle toxicity is increased if this drug is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

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

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

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

gemfibrozil 600 mg tablet, 60

9248R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	20.99	22.20	[a] Ausgem [RW]	[a] Lipigem [AF]

Bile acid sequestrants

▪ COLESTYRAMINE

colestyramine 4 g powder for oral liquid, 50 sachets

2967E

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*80.51	39.50	Questran Lite [QA]

▪ COLESTYRAMINE

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

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

Restricted benefit

Primary hypercholesterolaemia

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

colestyramine 4 g powder for oral liquid, 50 sachets

9249T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	11	..	*80.51	39.50	Questran Lite [QA]

Other lipid modifying agents

▪ EVOLOCUMAB

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

Note Special Pricing Arrangements apply.

Authority required

Familial homozygous hypercholesterolaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The condition must have been confirmed by genetic testing; OR
- The condition must have been confirmed by a Dutch Lipid Clinic Network Score of at least 7, **AND**
- Patient must have an LDL cholesterol level in excess of 3.3 millimoles per litre after at least 3 months of treatment at a maximum tolerated dose of an HMG CoA reductase inhibitor (statin), in conjunction with dietary therapy and exercise; OR
- Patient must have an LDL cholesterol level in excess of 3.3 millimoles per litre after having developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a withdrawal of statin treatment; OR
- Patient must have an LDL cholesterol level in excess of 3.3 millimoles per litre and must be one in whom treatment with an HMG CoA reductase inhibitor (statin) is contraindicated.

Treatment criteria:

- Must be treated by a consultant physician or in consultation with a consultant physician.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

The date of the consultation with a consultant physician must be no more than 6 months prior to the application for a PBS authority. The full name of the consultant physician consulted and the date of consultation are to be provided at the time of application.

The qualifying LDL cholesterol level must be provided at the time of application and must be no more than 2 months old. With the exception of patients contraindicated to a statin, the agent, dose and duration of statin treatment must be provided at the time of application.

The authority application must be made in writing and must include:

a) A completed authority prescription form; and

b) A completed Familial homozygous hypercholesterolaemia Initial PBS Authority Application - Supporting Information Form; and

c) The date of consultation and the full name of the consultant physician; and

d) A copy of the qualifying Dutch Lipid Clinic Network Score or a copy of the result of genetic testing; and

e) The result of LDL cholesterol level and one of the following where appropriate: statin treatment details including agent, dose and treatment duration; or details of adverse event or contraindication to treatment with a statin as defined in the TGA-approved Product Information.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Familial homozygous hypercholesterolaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be in conjunction with dietary therapy and exercise.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

evolocumab 140 mg/mL injection, 1 mL injection device

10958R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	5	..	*943.15	39.50	Repatha [AN]

evolocumab 420 mg/3.5 mL injection, 3.5 mL cartridge

11193D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	943.14	39.50	Repatha [AN]

▪ EZETIMIBE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

5537

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5543

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5538

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5544

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**

- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5594

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5586

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5575

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy

and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

5576

Hypercholesterolaemia

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be one in whom treatment with an HMG CoA reductase inhibitor (statin) is contraindicated.

Authority required (STREAMLINED)

5562

Hypercholesterolaemia

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the statin dose; OR
- Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a withdrawal of the statin treatment.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

Authority required (STREAMLINED)

5563

Homozygous sitosterolaemia

Authority required (STREAMLINED)

5577

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- The treatment must be co-administered with an HMG CoA reductase inhibitor (statin).

ezetimibe 10 mg tablet, 30

8757X

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	66.84	39.50	Ezetrol [MK]

LIPID MODIFYING AGENTS, COMBINATIONS

HMG CoA reductase inhibitors in combination with other lipid modifying agents

▪ EZETIMIBE + ATORVASTATIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

ezetimibe 10 mg + atorvastatin 20 mg tablet, 30

10393B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	69.10	39.50	Atozet [MK]

ezetimibe 10 mg + atorvastatin 40 mg tablet, 30

10377E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	70.01	39.50	Atozet [MK]

ezetimibe 10 mg + atorvastatin 80 mg tablet, 30

10376D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	71.38	39.50	Atozet [MK]

▪ EZETIMIBE + ATORVASTATIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that

threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4353

Hypercholesterolaemia

Clinical criteria:

- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**
- Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the atorvastatin dose.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

ezetimibe 10 mg + atorvastatin 10 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10392Y NP	1	5	..	68.37	39.50	Atozet [MK]

▪ EZETIMIBE + SIMVASTATIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol

per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**

- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

ezetimibe 10 mg + simvastatin 80 mg tablet, 30

8882L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP 1	5	..	70.17	39.50	Vytorin [MK]

ezetimibe 10 mg + simvastatin 40 mg tablet, 30

8881K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	69.17	39.50	Vytorin [MK]

▪ EZETIMIBE + SIMVASTATIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4147

Hypercholesterolaemia

Clinical criteria:

- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**
- Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the statin dose.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

ezetimibe 10 mg + simvastatin 20 mg tablet, 30

9484E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	68.46	39.50	Vytorin [MK]

ezetimibe 10 mg + simvastatin 10 mg tablet, 30

9483D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	67.96	39.50	Vytorin [MK]

▪ ROSUVASTATIN (&) EZETIMIBE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

rosuvastatin 40 mg tablet [30] (&) ezetimibe 10 mg tablet [30 tablets], 1 pack

10207F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	71.83	39.50	Rosuzet Composite Pack [MK]

rosuvastatin 20 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10201X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	70.33	39.50	Rosuzet Composite Pack [MK]

rosuvastatin 10 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10208G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	69.32	39.50	Rosuzet Composite Pack [MK]

▪ ROSUVASTATIN (&) EZETIMIBE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

- The treatment must be in conjunction with dietary therapy and exercise, **AND**
- Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
- Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

- Patient must have homozygous familial hypercholesterolaemia, **AND**
- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4147

Hypercholesterolaemia

Clinical criteria:

- Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**
- Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the statin dose.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

rosuvastatin 5 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10204C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	68.52	39.50	Rosuzet Composite Pack [MK]

HMG CoA reductase inhibitors, other combinations

▪ AMLODIPINE + ATORVASTATIN

Restricted benefit

Hypertension

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be currently receiving treatment with a dihydropyridine calcium channel blocker.

Restricted benefit

Angina

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be currently receiving treatment with a dihydropyridine calcium channel blocker.

Restricted benefit

Hypertension

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be one in whom blood pressure is inadequately controlled with other classes of antihypertensive agents, **AND**
- The treatment must be appropriate for use as adjunctive therapy with a dihydropyridine calcium channel blocker.

Restricted benefit

Angina

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must have angina which is inadequately controlled with other classes of anti-anginal agents, **AND**
- The treatment must be appropriate for use as adjunctive therapy with a dihydropyridine calcium channel blocker.

Restricted benefit

Hypertension

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be intolerant of the side effects of other classes of antihypertensive agents, **AND**
- Patient must be one in whom replacement therapy with a dihydropyridine calcium channel blocker would be appropriate.

Restricted benefit

Angina

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Lipid-Lowering Drugs, **AND**
- Patient must be intolerant of the side effects of other classes of anti-anginal agents, **AND**
- Patient must be one in whom replacement therapy with a dihydropyridine calcium channel blocker would be appropriate.

amlodipine 10 mg + atorvastatin 80 mg tablet, 30

9056P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.21	18.42	[a] APO-Amlodipine/Atorvastatin 10/80 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 10/80 [IB]
						[a] Cadivast 10/80 [AF]	
			[B]3.00	20.21	18.42	[a] Caduet 10/80 [PF]	

amlodipine 5 mg + atorvastatin 40 mg tablet, 30

9051J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.15	16.36	[a] APO-Amlodipine/Atorvastatin 5/40 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 5/40 [IB]
						[a] Cadivast 5/40 [AF]	
			[B]3.00	18.15	16.36	[a] Caduet 5/40 [PF]	

amlodipine 10 mg + atorvastatin 20 mg tablet, 30

9054M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.93	16.14	[a] APO-Amlodipine/Atorvastatin 10/20 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 10/20 [IB]
						[a] Cadivast 10/20 [AF]	
			[B]3.00	17.93	16.14	[a] Caduet 10/20 [PF]	

amlodipine 5 mg + atorvastatin 20 mg tablet, 30

9050H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.24	15.45	[a] APO-Amlodipine/Atorvastatin 5/20 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 5/20 [IB]
						[a] Cadivast 5/20 [AF]	
			[B]3.00	17.24	15.45	[a] Caduet 5/20 [PF]	

amlodipine 5 mg + atorvastatin 80 mg tablet, 30

9052K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.52	17.73	[a] APO-Amlodipine/Atorvastatin 5/80 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 5/80 [IB]
						[a] Cadivast 5/80 [AF]	
			[B]3.00	19.52	17.73	[a] Caduet 5/80 [PF]	

amlodipine 10 mg + atorvastatin 10 mg tablet, 30

9053L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.20	15.41	[a] APO-Amlodipine/Atorvastatin 10/10 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 10/10 [IB]
						[a] Cadivast 10/10 [AF]	
			[B]3.00	17.20	15.41	[a] Caduet 10/10 [PF]	

amlodipine 5 mg + atorvastatin 10 mg tablet, 30

9049G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.51	14.72	[a] APO-Amlodipine/Atorvastatin 5/10 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 5/10 [IB]
						[a] Cadivast 5/10 [AF]	
			[B]3.00	16.51	14.72	[a] Caduet 5/10 [PF]	

amlodipine 10 mg + atorvastatin 40 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9055N NP	1	5	..	15.84	17.05	[a] APO-Amlodipine/Atorvastatin 10/40 [TX]	[a] Blooms the Chemist Amlodipine/Atorvastatin 10/40 [IB]
						[a] Cadivast 10/40 [AF]	
			[B]3.00	18.84	17.05	[a] Caduet 10/40 [PF]	

▪ DERMATOLOGICALS

▪ ANTIFUNGALS FOR DERMATOLOGICAL USE

ANTIFUNGALS FOR TOPICAL USE

Antibiotics

▪ NYSTATIN

Authority required (STREAMLINED)

6434

Fungal or yeast infection

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

nystatin 100 000 units/g cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1698J NP	2	3	..	*21.11	22.32	Mycostatin [FM]

Imidazole and triazole derivatives

▪ KETOCONAZOLE

Authority required (STREAMLINED)

6434

Fungal or yeast infection

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

ketoconazole 2% cream, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9024Y NP	‡1	2	..	25.63	26.84	Nizoral 2% Cream [JT]

ketoconazole 2% shampoo, 60 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1574W NP	‡1	1	..	21.58	22.79	Nizoral 2% [JT]

ketoconazole 1% shampoo, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9025B NP	‡1	1	..	20.95	22.16	Nizoral 1% [JT]

▪ MICONAZOLE

Authority required (STREAMLINED)

6434

Fungal or yeast infection

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

miconazole nitrate 2% dusting powder, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9029F NP	‡1	2	..	19.32	20.53	Daktarin [JT]

miconazole nitrate 2% cream, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9027D NP	‡1	2	..	18.59	19.80	Daktarin [JT]

miconazole 2% solution, 30 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9031H NP	‡1	2	..	22.56	23.77	Daktarin Tincture [JT]

miconazole nitrate 2% cream, 70 g

9028E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	20.27	21.48	Daktarin [JT]

Other antifungals for topical use

▪ TERBINAFINE

Authority required (STREAMLINED)

6434

Fungal or yeast infection

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Authority required (STREAMLINED)

6412

Fungal or yeast infection

Clinical criteria:

- The condition must be fungal; OR
- The condition must be due to yeast.

Population criteria:

- Patient must be 18 years of age or less.

terbinafine hydrochloride 1% cream, 15 g

9160D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*37.99	39.20	[a] Lamisil [GK]

ANTIFUNGALS FOR SYSTEMIC USE

Antifungals for systemic use

▪ GRISEOFULVIN

griseofulvin 500 mg tablet, 28

2982Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	28.09	29.30	Grisovin 500 [QA]

griseofulvin 125 mg tablet, 100

1460W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	27.15	28.36	Grisovin [QA]

▪ TERBINAFINE

Authority required

Dermatophyte infection

Clinical criteria:

- Patient must have failed to respond to topical treatment.

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Authority required

Dermatophyte infection

Clinical criteria:

- Patient must have failed to respond to topical treatment, **AND**
- Patient must have failed to respond to griseofulvin.

Population criteria:

- Patient must be 18 years of age or less.

terbinafine 250 mg tablet, 42

2285G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	30.00	31.21	[a] APO-Terbinafine [TX]	[a] GenRx Terbinafine [GX]
						[a] Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV]	[a] Tamsil [RW]
						[a] Terbinafine AN [EA]	[a] Terbinafine-DRLA [RZ]
						[a] Terbinafine GH [GQ]	[a] Terbinafine Sandoz [SZ]
						[a] Tinasil [AF]	

▪ TERBINAFINE

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

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

Authority required

Onychomycosis

Clinical criteria:

- The condition must be proximal or extensive (greater than 80% nail involvement), **AND**
- Patient must have failed to respond to topical treatment, **AND**
- The condition must be due to dermatophyte infection proven by microscopy and confirmed by an Approved Pathology Provider; OR
- The condition must be due to dermatophyte infection proven by culture and confirmed by an Approved Pathology Provider.

The date of the pathology report must be provided at the time of application and must not be more than 12 months old

terbinafine 250 mg tablet, 42

2804N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	30.00	31.21	[a] APO-Terbinafine [TX] [a] Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV] [a] Terbinafine AN [EA] [a] Terbinafine GH [GQ] [a] Tinasil [AF]	[a] GenRx Terbinafine [GX] [a] Tamsil [RW] [a] Terbinafine-DRLA [RZ] [a] Terbinafine Sandoz [SZ]

ANTIPSORIATICS

ANTIPSORIATICS FOR TOPICAL USE

Tars

PREPARED COAL TAR

coal tar prepared 2% foam, 100 g

10225E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	34.27	35.48	Scytera [RZ]

Other antipsoriatics for topical use

CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6873

Chronic stable plaque type psoriasis vulgaris

Clinical criteria:

- The condition must be inadequately controlled by potent topical corticosteroid monotherapy, **AND**
- Patient must require more than 30 grams of product per month.

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% gel, 60 g

10075G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	63.11	39.50	Daivobet 50/500 gel [LO]

CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Restricted benefit

Chronic stable plaque type psoriasis vulgaris

Clinical criteria:

- The condition must be inadequately controlled by potent topical corticosteroid monotherapy.

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% gel, 30 g

5276Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	37.10	38.31	Daivobet 50/500 gel [LO]

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% ointment, 30 g

9494Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	37.10	38.31	[a] Calcipotriol/Betamethasone Sandoz 50/500 [SZ]	[a] Daivobet [LO]

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% foam, 60 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11091R NP	‡1	1	..	83.33	39.50	Enstilar [LO]

ANTIPSORIATICS FOR SYSTEMIC USE

Retinoids for treatment of psoriasis

▪ ACITRETIN

Caution This drug is a potent teratogen - pregnancy should be avoided for at least two years after cessation of therapy.

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Authority required (STREAMLINED)
5789
Severe intractable psoriasis
Authority required (STREAMLINED)
5727
Severe disorders of keratinisation

acitretin 25 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2020H	1	2	..	207.38	39.50	[a] Neotigason [UA] [a] ZETIN [RW]	[a] Novatin [TX]

acitretin 10 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2019G	1	2	..	107.34	39.50	[a] Neotigason [UA] [a] ZETIN [RW]	[a] Novatin [TX]

▪ ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE

CHEMOTHERAPEUTICS FOR TOPICAL USE

Sulfonamides

▪ SILVER SULFADIAZINE

Restricted benefit
Infection
Treatment Phase: Prevention and treatment
Clinical criteria:
- The condition must be in partial or full skin thickness loss due to burns; OR
- The condition must be in partial or full skin thickness loss due to epidermolysis bullosa.

Restricted benefit
Stasis ulcers

silver sulfadiazine 1% cream, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9479X NP	‡1	..	..	21.62	22.83	Flamazine [SN]

▪ CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS

CORTICOSTEROIDS, PLAIN

Corticosteroids, weak (group I)

▪ HYDROCORTISONE ACETATE

Restricted benefit
Corticosteroid-responsive dermatoses

hydrocortisone acetate 1% cream, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2881P NP	‡1	1	..	12.95	14.16	[a] Cortic-DS 1% [FM]
			[B]2.35	15.30	14.16	[a] Sigmacort [QA]

hydrocortisone acetate 1% ointment, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2882Q NP	‡1	1	..	12.95	14.16	[a] Cortic-DS 1% [FM]
			[B]2.35	15.30	14.16	[a] Sigmacort [QA]

▪ HYDROCORTISONE ACETATE

Restricted benefit
Corticosteroid-responsive dermatoses

hydrocortisone acetate 1% cream, 50 g

5113D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	12.95	14.16	[a] Cortic-DS 1% [FM]
			[B]2.35	15.30	14.16	[a] Sigmacort [QA]

hydrocortisone acetate 1% ointment, 50 g

5114E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	12.95	14.16	[a] Cortic-DS 1% [FM]
			[B]2.35	15.30	14.16	[a] Sigmacort [QA]

Corticosteroids, moderately potent (group II)

▪ TRIAMCINOLONE

Restricted benefit

Corticosteroid-responsive dermatoses

triamcinolone acetonide 0.02% cream, 100 g

2117K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*18.03	19.24	[a] Tricortone [FM]
			[B]3.28	*21.31	19.24	[a] Aristocort 0.02% [QA]

triamcinolone acetonide 0.02% ointment, 100 g

2118L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*18.03	19.24	[a] Tricortone [FM]
			[B]3.28	*21.31	19.24	[a] Aristocort 0.02% [QA]

Corticosteroids, potent (group III)

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Restricted benefit

Corticosteroid-responsive dermatoses

betamethasone (as dipropionate) 0.05% ointment, 15 g

1119X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	16.93	18.14	[a] Eleuphrat [FR]
			[B]2.45	19.38	18.14	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

1115Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	16.93	18.14	[a] Eleuphrat [FR]
			[B]2.45	19.38	18.14	[a] Diprosone [MK]

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6232

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 10-20% of the patient's body surface area.

betamethasone (as dipropionate) 0.05% ointment, 15 g

10795E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*22.77	23.98	[a] Eleuphrat [FR]
			[B]4.90	*27.67	23.98	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

10824Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*22.77	23.98	[a] Eleuphrat [FR]
			[B]4.90	*27.67	23.98	[a] Diprosone [MK]

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a

patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

6246

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 20-40% of the patient's body surface area.

betamethasone (as dipropionate) 0.05% ointment, 15 g

10820L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*34.47	35.68	[a] Eleuphrat [FR]
			[B]9.80	*44.27	35.68	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

10800K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*34.47	35.68	[a] Eleuphrat [FR]
			[B]9.80	*44.27	35.68	[a] Diprosone [MK]

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6218

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 40-60% of the patient's body surface area.

betamethasone (as dipropionate) 0.05% ointment, 15 g

10821M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*46.15	39.50	[a] Eleuphrat [FR]
			[B]14.70	*60.85	39.50	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

10813D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*46.15	39.50	[a] Eleuphrat [FR]
			[B]14.70	*60.85	39.50	[a] Diprosone [MK]

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6263

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 60-80% of the patient's body surface area.

betamethasone (as dipropionate) 0.05% ointment, 15 g

10816G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*57.79	39.50	[a] Eleuphrat [FR]
			[B]19.60	*77.39	39.50	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

10801L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*57.79	39.50	[a] Eleuphrat [FR]
			[B]19.60	*77.39	39.50	[a] Diprosone [MK]

▪ BETAMETHASONE DIPROPIONATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6231

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover >80% of the patient's body surface area.

betamethasone (as dipropionate) 0.05% ointment, 15 g

10823P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	5	..	*69.45	39.50	[a] Eleuphrat [FR]
			[B]24.50	*93.95	39.50	[a] Diprosone [MK]

betamethasone (as dipropionate) 0.05% cream, 15 g

10802M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	5	..	*69.45	39.50	[a] Eleuphrat [FR]
			[B]24.50	*93.95	39.50	[a] Diprosone [MK]

▪ BETAMETHASONE VALERATE

Restricted benefit

Corticosteroid-responsive dermatoses

betamethasone (as valerate) 0.02% cream, 100 g

2812B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*26.57	27.78	[a] Antroquoril [FR] [b] Cortival 1/5 [FM]
			[B]5.00	*31.57	27.78	[a] Celestone-M [MK]
			[B]5.98	*32.55	27.78	[b] Betnovate 1/5 [QA]

▪ BETAMETHASONE VALERATE

Note Continuing Therapy Only:

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

Restricted benefit

Corticosteroid-responsive dermatoses

betamethasone (as valerate) 0.05% cream, 15 g

2813C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.82	14.03	[a] Cortival 1/2 [FM]
			[B]2.56	15.38	14.03	[a] Betnovate 1/2 [QA]

▪ BETAMETHASONE VALERATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6232

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 10-20% of the patient's body surface area.

betamethasone (as valerate) 0.05% cream, 15 g

10799J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*14.55	15.76	[a] Cortival 1/2 [FM]
			[B]5.12	*19.67	15.76	[a] Betnovate 1/2 [QA]

▪ BETAMETHASONE VALERATE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6246

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 20-40% of the patient's body surface area.

betamethasone (as valerate) 0.05% cream, 15 g

10794D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*18.03	19.24	[a] Cortival 1/2 [FM]
			[B]10.24	*28.27	19.24	[a] Betnovate 1/2 [QA]

▪ BETAMETHASONE VALERATE

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

Authority required (STREAMLINED)
6218
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover 40-60% of the patient's body surface area.

betamethasone (as valerate) 0.05% cream, 15 g

10808W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*21.49	22.70	[a] Cortival 1/2 [FM]
			[B]15.36	*36.85	22.70	[a] Betnovate 1/2 [QA]

▪ BETAMETHASONE VALERATE

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

Authority required (STREAMLINED)
6263
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover 60-80% of the patient's body surface area.

betamethasone (as valerate) 0.05% cream, 15 g

10807T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*24.91	26.12	[a] Cortival 1/2 [FM]
			[B]20.48	*45.39	26.12	[a] Betnovate 1/2 [QA]

▪ BETAMETHASONE VALERATE

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

Authority required (STREAMLINED)
6231
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover >80% of the patient's body surface area.

betamethasone (as valerate) 0.05% cream, 15 g

10810Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	5	..	*28.35	29.56	[a] Cortival 1/2 [FM]
			[B]25.60	*53.95	29.56	[a] Betnovate 1/2 [QA]

▪ METHYLPREDNISOLONE

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

Restricted benefit
Corticosteroid-responsive dermatoses

methylprednisolone aceponate 0.1% cream, 15 g

8054X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	17.66	18.87	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

8055Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	17.66	18.87	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

8128T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	17.66	18.87	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Restricted benefit
Eczema

methylprednisolone aceponate 0.1% lotion, 20 g

8618N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	18.25	19.46	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6232
Corticosteroid-responsive dermatoses
Clinical criteria:
- The condition must cover 10-20% of the patient's body surface area.

methylprednisolone aceponate 0.1% cream, 15 g

10842P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*24.23	25.44	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

10846W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*24.23	25.44	Advantan [BN]

methylprednisolone aceponate 0.1% lotion, 20 g

10856J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*25.41	26.62	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

10848Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*24.23	25.44	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6246
Corticosteroid-responsive dermatoses
Clinical criteria:
- The condition must cover 20-40% of the patient's body surface area.

methylprednisolone aceponate 0.1% cream, 15 g

10855H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*37.39	38.60	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

10836H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*37.39	38.60	Advantan [BN]

methylprednisolone aceponate 0.1% lotion, 20 g

10838K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*32.56	33.77	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

10840M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*37.39	38.60	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6231
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover >80% of the patient's body surface area.

methylprednisolone aceponate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10833E NP	10	5	..	*76.75	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10845T NP	10	5	..	*76.75	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% lotion, 20 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10830B NP	5	5	..	*46.90	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10843Q NP	10	5	..	*76.75	39.50	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6218
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover 40-60% of the patient's body surface area.

methylprednisolone aceponate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10835G NP	6	5	..	*50.53	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10853F NP	6	5	..	*50.53	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10844R NP	6	5	..	*50.53	39.50	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6263
Corticosteroid-responsive dermatoses
Clinical criteria:

- The condition must cover 60-80% of the patient's body surface area.

methylprednisolone aceponate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10851D NP	8	5	..	*63.63	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment, 15 g

10834F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*63.63	39.50	Advantan [BN]

methylprednisolone aceponate 0.1% ointment: fatty, 15 g

10839L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*63.63	39.50	Advantan [BN]

▪ METHYLPREDNISOLONE

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

Authority required (STREAMLINED)
6263
Corticosteroid-responsive dermatoses
Clinical criteria:
- The condition must cover 60-80% of the patient's body surface area.

Authority required (STREAMLINED)
6218
Corticosteroid-responsive dermatoses
Clinical criteria:
- The condition must cover 40-60% of the patient's body surface area.

methylprednisolone aceponate 0.1% lotion, 20 g

10852E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*39.75	39.50	Advantan [BN]

▪ MOMETASONE

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

Restricted benefit
Corticosteroid-responsive dermatoses

mometasone furoate 0.1% lotion, 30 mL

8043H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	16.32	17.53	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]3.53	19.85	17.53	[a] Elocon [MK]	

mometasone furoate 0.1% cream, 15 g

1913Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.40	15.61	[a] Momasone [QA]	[a] Novasone [AF]
			[B]3.53	17.93	15.61	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

1915T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.40	15.61	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]3.53	17.93	15.61	[a] Elocon [MK]	

▪ MOMETASONE

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

Authority required (STREAMLINED)
6232
Corticosteroid-responsive dermatoses
Clinical criteria:
- The condition must cover 10-20% of the patient's body surface area.

mometasone furoate 0.1% lotion, 30 mL

10819K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*21.55	22.76	[a] Momasone [QA]	[a] Novasone [AF]

							[a] Zatamil [EO]	
			[B]7.06	*28.61	22.76	[a] Elocon [MK]		

mometasone furoate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10827W							
NP	2	5	..	*17.71	18.92	[a] Momasone [QA]	[a] Novasone [AF]
			[B]7.06	*24.77	18.92	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10812C							
NP	2	5	..	*17.71	18.92	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]7.06	*24.77	18.92	[a] Elocon [MK]	

▪ MOMETASONE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6246

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 20-40% of the patient's body surface area.

mometasone furoate 0.1% lotion, 30 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10826T							
NP	3	5	..	*26.77	27.98	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]10.59	*37.36	27.98	[a] Elocon [MK]	

mometasone furoate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10809X							
NP	4	5	..	*24.35	25.56	[a] Momasone [QA]	[a] Novasone [AF]
			[B]14.12	*38.47	25.56	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10814E							
NP	4	5	..	*24.35	25.56	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]14.12	*38.47	25.56	[a] Elocon [MK]	

▪ MOMETASONE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6218

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 40-60% of the patient's body surface area.

mometasone furoate 0.1% cream, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10815F							
NP	6	5	..	*30.97	32.18	[a] Momasone [QA]	[a] Novasone [AF]
			[B]21.18	*52.15	32.18	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10828X							
NP	6	5	..	*30.97	32.18	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]21.18	*52.15	32.18	[a] Elocon [MK]	

▪ MOMETASONE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6263

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 60-80% of the patient's body surface area.

mometasone furoate 0.1% cream, 15 g

10818J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	8	5	..	*37.55	38.76	[a] Momasone [QA]	[a] Novasone [AF]
			[B]28.24	*65.79	38.76	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

10793C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	8	5	..	*37.55	38.76	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]28.24	*65.79	38.76	[a] Elocon [MK]	

▪ MOMETASONE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6231

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover >80% of the patient's body surface area.

mometasone furoate 0.1% lotion, 30 mL

10804P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	5	..	*37.25	38.46	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]17.65	*54.90	38.46	[a] Elocon [MK]	

mometasone furoate 0.1% cream, 15 g

10792B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	5	..	*44.15	39.50	[a] Momasone [QA]	[a] Novasone [AF]
			[B]35.30	*79.45	39.50	[a] Elocon Alcohol Free [MK]	

mometasone furoate 0.1% ointment, 15 g

10791Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	5	..	*44.15	39.50	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]35.30	*79.45	39.50	[a] Elocon [MK]	

▪ MOMETASONE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6263

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 60-80% of the patient's body surface area.

Authority required (STREAMLINED)

6218

Corticosteroid-responsive dermatoses

Clinical criteria:

- The condition must cover 40-60% of the patient's body surface area.

mometasone furoate 0.1% lotion, 30 mL

10805Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	5	..	*32.03	33.24	[a] Momasone [QA] [a] Zatamil [EO]	[a] Novasone [AF]
			[B]14.12	*46.15	33.24	[a] Elocon [MK]	

Corticosteroids, very potent (group IV)

▪ CLOBETASOL

Authority required (STREAMLINED)

5461

Moderate to severe scalp psoriasis

Clinical criteria:

- The condition must be inadequately controlled with either a vitamin D analogue or potent topical corticosteroid as monotherapy; OR
- The condition must be inadequately controlled with combination use of a vitamin D analogue and potent topical corticosteroid.

Population criteria:

- Patient must be aged 18 years or older.

clobetasol propionate 0.05% shampoo, 125 mL

10080M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	48.81	39.50	Clobex [GA]

▪ ANTI-ACNE PREPARATIONS

ANTI-ACNE PREPARATIONS FOR TOPICAL USE

Retinoids for topical use in acne

▪ ADAPALENE + BENZOYL PEROXIDE

Restricted benefit

Severe acne vulgaris

Treatment Phase: Acute treatment

Clinical criteria:

- The treatment must in combination with an oral antibiotic.

adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g

8954G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	36.29	37.50	Epiduo [GA]

▪ ADAPALENE + BENZOYL PEROXIDE

Note Continuing Therapy Only:

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

Restricted benefit

Severe acne vulgaris

Clinical criteria:

- The treatment must be maintenance therapy.

adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g

8955H

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	3	..	36.29	37.50	Epiduo [GA]

ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE

Retinoids for treatment of acne

▪ ISOTRETINOIN

Caution This drug causes birth defects.

This drug has been reported to cause other frequent and potentially serious toxicity.

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Authority required (STREAMLINED)

5224

Severe cystic acne

Clinical criteria:

- The condition must be unresponsive to other therapy.

isotretinoin 10 mg capsule, 60

2591J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	34.77	35.98	[a] APO-Isotretinoin [TX] [a] Isotretinoin AN [EA] [a] Rocta 10 [RW]	[a] Dermatane [ER] [a] Oratane [RF]

isotretinoin 40 mg capsule, 30

2549E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	44.40	39.50	[a] Dermatane [ER]	[a] Oratane [RF]

isotretinoin 20 mg capsule, 60

2592K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	47.99	39.50	[a] APO-Isotretinoin [TX] [a] Isotretinoin AN [EA] [a] Oratane [RF] [a] Rocta 20 [RW]	[a] Dermatane [ER] [a] Isotretinoin SCP 20 [CR] [a] Roaccutane [RO]

▪ OTHER DERMATOLOGICAL PREPARATIONS

OTHER DERMATOLOGICAL PREPARATIONS

Agents for dermatitis, excluding corticosteroids

▪ PIMECROLIMUS

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

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

Authority required (STREAMLINED)

5482

Atopic dermatitis

Population criteria:

- Patient must be at least 3 months of age.

Clinical criteria:

- The condition must be on the patient's face; OR
- The condition must be on the patient's eyelid, **AND**
- Patient must have 1 or more of the following contraindications to topical corticosteroids: (i) perioral dermatitis; (ii) periorbital dermatitis; (iii) rosacea; (iv) epidermal atrophy; (v) dermal atrophy; (vi) allergy to topical corticosteroids; (vii) cataracts; (viii) glaucoma; (ix) raised intraocular pressure, **AND**
- Patient must not receive more than two 15 g packs of PBS-subsidised pimecrolimus per 6-month period.

Authority required (STREAMLINED)

5472

Atopic dermatitis

Treatment Phase: Short-term (up to 3 weeks) intermittent treatment

Population criteria:

- Patient must be at least 3 months of age.

Clinical criteria:

- The condition must be on the patient's face; OR
- The condition must be on the patient's eyelid, **AND**
- Patient must have failed to achieve satisfactory disease control with intermittent topical corticosteroid therapy, **AND**
- The condition must have been initially diagnosed more than three months prior to this treatment, **AND**
- Patient must not receive more than two 15 g packs of PBS-subsidised pimecrolimus per 6-month period.

Failure to achieve satisfactory disease control with intermittent topical corticosteroid therapy is manifest by:

(i) failure of the facial skin to clear despite at least 2 weeks of topical hydrocortisone 1% applied every day; or

(ii) failure of the facial skin to clear despite at least 1 week of a moderate or potent topical corticosteroid applied every day; or

(iii) clearing of the facial skin with at least 2 weeks of topical hydrocortisone 1% applied every day, but almost immediate and significant flare in facial disease (within 48 hours) upon stopping topical corticosteroids, occurring on at least 2 consecutive occasions; or

(iv) clearing of the facial skin with at least 1 week of a moderate or potent topical corticosteroid applied every day, but almost immediate and significant flare in facial disease (within 48 hours) upon stopping topical corticosteroids, occurring on at least 2 consecutive occasions

pimecrolimus 1% cream, 15 g

8802G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	33.70	34.91	Elidel [HM]

Other dermatologicals

▪ DAPSONE

Note Shared Care Model:

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

dapsone 25 mg tablet, 100

8801F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	288.57	39.50	Link Medical Products Pty Ltd [LM]

dapsone 100 mg tablet, 100

1272Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	353.02	39.50	Link Medical Products Pty Ltd [LM]

▪ IMIQUIMOD

Note The patient or carer must be able to understand and administer the imiquimod dosing regimen.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Treatment of recurrent (previously treated) lesions will not be authorised.
Note Pharmaceutical benefits that have the form imiquimod single use sachets and pharmaceutical benefits that have the form imiquimod multi-use pump are equivalent for the purposes of substitution.

Authority required
Superficial basal cell carcinoma
Clinical criteria:
- The condition must be previously untreated, **AND**
- The condition must be confirmed by biopsy, **AND**
- Patient must have normal immune function, **AND**
- The condition must not be suitable for treatment with surgical excision; OR
- The condition must not be suitable for treatment with cryotherapy; OR
- The condition must not be suitable for treatment with curettage with diathermy, **AND**
- Patient must require topical drug therapy.

The date of the pathology report and name of the Approved Pathology Authority must be provided at the time of application.

imiquimod 5% cream, 2 x 2 g

2637T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	[B]4.55	91.17	39.50	[a] Aldara Pump [IA]

imiquimod 5% cream, 12 x 250 mg sachets

2546B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	86.62	39.50	[a] Aldiq [QA]	[a] APO-Imiquimod [TX]
			[B]2.28	88.90	39.50	[a] Aldara [IA]	

▪ GENITO URINARY SYSTEM AND SEX HORMONES

▪ OTHER GYNECOLOGICALS

CONTRACEPTIVES FOR TOPICAL USE

Intrauterine contraceptives

▪ LEVONORGESTREL

Restricted benefit
Contraception
Restricted benefit
Idiopathic menorrhagia
Clinical criteria:
- The treatment must be in a patient where oral treatments are ineffective.

Restricted benefit
Idiopathic menorrhagia
Clinical criteria:
- The treatment must be in a patient where oral treatments are contraindicated.

levonorgestrel 52 mg intrauterine drug delivery system, 1 system

8633J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	242.55	39.50	Mirena [BN]

OTHER GYNECOLOGICALS

Prolactine inhibitors

▪ BROMOCRIPTINE

Restricted benefit
Prevention of the onset of lactation

Clinical criteria:

- The treatment must occur in the puerperium, **AND**
- The treatment must be for medical reasons.

bromocriptine 2.5 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1444B NP	1	..	..	21.96	23.17	Parlodel [SZ]

▪ BROMOCRIPTINE

Caution Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Restricted benefit

Acromegaly

Restricted benefit

Parkinson disease

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must be one in whom surgery is not indicated.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must have had surgery for this condition with incomplete resolution.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must be one in whom radiotherapy is not indicated.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must have had radiotherapy for this condition with incomplete resolution.

bromocriptine 2.5 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1443Y	2	5	..	*32.83	34.04	Parlodel [SZ]

▪ CABERGOLINE

Restricted benefit

Prevention of the onset of lactation

Clinical criteria:

- The treatment must occur in the puerperium, **AND**
- The treatment must be for medical reasons.

cabergoline 500 microgram tablet, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8115D NP	1	..	..	24.45	25.66	[a] APO-Cabergoline [TX]	[a] Dostinex [PF]

▪ CABERGOLINE

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must be one in whom surgery is not indicated.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must have had surgery for this condition with incomplete resolution.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must be one in whom radiotherapy is not indicated.

Restricted benefit

Pathological hyperprolactinaemia

Clinical criteria:

- Patient must have had radiotherapy for this condition with incomplete resolution.

cabergoline 500 microgram tablet, 8

8114C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	64.55	39.50	[a] APO-Cabergoline [TX]	[a] Dostinex [PF]

▪ QUINAGOLIDE

Restricted benefit
Pathological hyperprolactinaemia
Clinical criteria:
- Patient must be one in whom surgery is not indicated.

Restricted benefit
Pathological hyperprolactinaemia
Clinical criteria:
- Patient must have had surgery for this condition with incomplete resolution.

Restricted benefit
Pathological hyperprolactinaemia
Clinical criteria:
- Patient must be one in whom radiotherapy is not indicated.

Restricted benefit
Pathological hyperprolactinaemia
Clinical criteria:
- Patient must have had radiotherapy for this condition with incomplete resolution.

quinagolide 75 microgram tablet, 30

8822H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	52.76	39.50	Norprolac [FP]

quinagolide 25 microgram tablet [3 tablets] (&) quinagolide 50 microgram tablet [3 tablets], 6

8860H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	..	..	15.26	16.47	Norprolac [FP]

▪ SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE

Progestogens and estrogens, fixed combinations

▪ LEVONORGESTREL + ETHINYLESTRADIOL

levonorgestrel 125 microgram + ethinylestradiol 50 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

1456P NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	18.81	20.02	Microgynon 50 ED [BN]

levonorgestrel 100 microgram + ethinylestradiol 20 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

2416E NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	17.20	18.41	Femme-Tab ED 20/100 [AE]

levonorgestrel 150 microgram + ethinylestradiol 30 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

1394J NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	17.20	18.41	[a] Monofeme 28 [FZ]	
					[b] Eleanor 150/30 ED [EA]	[b] Evelyn 150/30 ED [GQ]
					[b] Femme-Tab ED 30/150 [AE]	[b] Lenest 30 ED [AF]
					[b] Micronelle 30 ED [TX]	
		[B]3.25	20.45	18.41	[b] Levlen ED [SY]	
		[B]11.56	28.76	18.41	[a] Nordette 28 [PF]	

▪ NORETHISTERONE + ETHINYLESTRADIOL

norethisterone 1 mg + ethinylestradiol 35 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

2775C NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	19.82	21.03	[a] Norimin-1 28 Day [FZ]
		[B]9.78	29.60	21.03	[a] Brevinor-1 [PF]

norethisterone 500 microgram + ethinylestradiol 35 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

2774B NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	19.82	21.03	[a] Norimin 28 Day [FZ]
		[B]9.78	29.60	21.03	[a] Brevinor [PF]

▪ NORETHISTERONE + MESTRANOL

norethisterone 1 mg + mestranol 50 microgram tablet [21] (&) inert substance tablet [7], 4 x 28

3179H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	19.82	21.03	Norinyl-1/28 [PF]

Progestogens and estrogens, sequential preparations

▪ LEVONORGESTREL + ETHINYLESTRADIOL

ethinylestradiol 30 microgram + levonorgestrel 50 microgram tablet [24] (&) ethinylestradiol 40 microgram + levonorgestrel 75 microgram tablet [20] (&) ethinylestradiol 30 microgram + levonorgestrel 125 microgram tablet [40] (&) inert substance tablet [28], 112 [4 x 28]

1392G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	18.81	20.02	[a] Trifeme 28 [FZ] [b] Logynon ED [SY]
			[B]11.41	30.22	20.02	[b] Triquilar ED [BN]
			[B]13.00	31.81	20.02	[a] Triphasil 28 [PF]

Progestogens

▪ ETONOGESTREL

etonogestrel 68 mg implant, 1

8487Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	1	..	..	193.08	39.50	Implanon NXT [MK]

▪ LEVONORGESTREL

levonorgestrel 30 microgram tablet, 112 tablets [4 x 28]

2913H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	1	2	..	20.10	21.31	Microlut 28 [BN]

▪ MEDROXYPROGESTERONE

medroxyprogesterone acetate 150 mg/mL injection, 1 mL vial

3118D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	25.22	26.43	[a] Depo-Ralovera [FZ]
			[B]7.00	32.22	26.43	[a] Depo-Provera [PF]

▪ NORETHISTERONE

norethisterone 350 microgram tablet, 4 x 28

1967M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	19.82	21.03	Noriday 28 Day [PF]

ANDROGENS

3-oxoandrosten (4) derivatives

▪ TESTOSTERONE

Authority required

Androgen deficiency

Clinical criteria:

- Patient must have an established pituitary or testicular disorder.

Treatment criteria:

- Must be treated by a specialist general paediatrician, specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Androgen deficiency

Clinical criteria:

- Patient must not have an established pituitary or testicular disorder, **AND**
- The condition must not be due to age, obesity, cardiovascular diseases, infertility or drugs.

Population criteria:

- Patient must be aged 40 years or older.

Treatment criteria:

- Must be treated by a specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

Androgen deficiency is defined as:

(i) testosterone level of less than 6 nmol per litre; OR
(ii) testosterone level between 6 and 15 nmol per litre with high luteinising hormone (LH) (greater than 1.5 times the upper limit of the eugonodal reference range for young men, or greater than 14 IU per litre, whichever is higher).
Androgen deficiency must be confirmed by at least two morning blood samples taken on different mornings.
The dates and levels of the qualifying testosterone and LH measurements must be, or must have been provided in the authority application when treatment with this drug is or was initiated.
The name of the specialist must be included in the authority application.

Authority required

Micropenis

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician, specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Pubertal induction

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician, specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Constitutional delay of growth or puberty

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician, specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

testosterone 1% (50 mg/5 g) gel, 30 x 5 g sachets

8830R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	87.70	39.50	Testogel [HB]

testosterone 5 mg/24 hours patch, 30

8619P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	88.31	39.50	Androderm [GN]

testosterone 5% (50 mg/mL) cream, 50 mL

10378F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	6	..	73.95	39.50	AndroForte 5 [LX]

testosterone 2.5 mg/24 hours patch, 60

8460G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	88.31	39.50	Androderm [GN]

testosterone 1% (12.5 mg/actuation) gel, 2 x 60 actuations

10380H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	4	..	87.70	39.50	Testogel [HB]

▪ TESTOSTERONE UNDECANOATE

Authority required

Androgen deficiency

Clinical criteria:

- Patient must have an established pituitary or testicular disorder.

Treatment criteria:

- Must be treated by a specialist general paediatrician, specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Androgen deficiency

Clinical criteria:

- Patient must not have an established pituitary or testicular disorder, **AND**
- The condition must not be due to age, obesity, cardiovascular diseases, infertility or drugs.

Population criteria:

- Patient must be aged 40 years or older.

Treatment criteria:

- Must be treated by a specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

Androgen deficiency is defined as:

(i) testosterone level of less than 6 nmol per litre; OR

(ii) testosterone level between 6 and 15 nmol per litre with high luteinising hormone (LH) (greater than 1.5 times the upper limit of the eugonodal reference range for young men, or greater than 14 IU per litre, whichever is higher).

Androgen deficiency must be confirmed by at least two morning blood samples taken on different mornings.

The dates and levels of the qualifying testosterone and LH measurements must be, or must have been provided in the authority application when treatment with this drug is or was initiated.

The name of the specialist must be included in the authority application.

Authority required

Micropenis

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician**,** specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Pubertal induction

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician**,** specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Constitutional delay of growth or puberty

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a specialist general paediatrician**,** specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a Fellow of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

testosterone undecanoate 40 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2115H	1	5	..	36.79	38.00	Andriol Testocaps [MK]

testosterone undecanoate 1 g/4 mL injection, 4 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10205D	1	1	..	132.86	39.50	Reandron 1000 [BN]

ESTROGENS

Natural and semisynthetic estrogens, plain

▪ ESTRADIOL

Note Continuing Therapy Only:

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

estradiol 2 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8274L NP	1	2	..	17.29	18.50	Zumenon [GO]

estradiol valerate 1 mg tablet, 56

1663M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	15.66	16.87	Progynova [BN]

estradiol 10 microgram modified release pessary, 18

10203B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	33.16	34.37	Vagifem Low [NO]

estradiol valerate 2 mg tablet, 56

1664N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	17.59	18.80	Progynova [BN]

▪ ESTRADIOL

Note Oestradiol should be used in conjunction with an oral progestogen in women with an intact uterus.

Note Continuing Therapy Only:

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

estradiol 100 microgram/24 hours patch, 4

8126Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.14	23.35	Climara 100 [BN]

estradiol 75 microgram/24 hours patch, 4

8486P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.14	23.35	Climara 75 [BN]

estradiol 75 microgram/24 hours patch, 8

8764G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.14	23.35	Estradot 75 [SZ]

estradiol 25 microgram/24 hours patch, 4

8485N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Climara 25 [BN]

estradiol 50 microgram/24 hours patch, 8

8140K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Estraderm MX 50 [JU]

estradiol 50 microgram/24 hours patch, 8

8763F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Estradot 50 [SZ]

estradiol 25 microgram/24 hours patch, 8

8311K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Estraderm MX 25 [JU]

estradiol 25 microgram/24 hours patch, 8

8761D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Estradot 25 [SZ]

estradiol 0.1% (1 mg/g) gel, 28 x 1 g sachets

8286D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Sandrena [AS]

estradiol 50 microgram/24 hours patch, 4

8125P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Climara 50 [BN]

estradiol 37.5 microgram/24 hours patch, 8

8762E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	20.37	21.58	Estradot 37.5 [SZ]

estradiol 100 microgram/24 hours patch, 8

8312L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.14	23.35	Estraderm MX 100 [JU]

estradiol 100 microgram/24 hours patch, 8

8765H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.14	23.35	Estradot 100 [SZ]

▪ ESTRIOL

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

estriol 500 microgram pessary, 15

1771F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	23.35	24.56	Ovestin Ovula [AS]

estriol 0.1% (1 mg/g) cream, 15 g

1781R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	21.56	22.77	Ovestin [AS]

PROGESTOGENS

Pregnen (4) derivatives

▪ MEDROXYPROGESTERONE

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

medroxyprogesterone acetate 5 mg tablet, 56

2323G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	19.09	20.30	[a] Ralovera [FZ]
			[B]6.70	25.79	20.30	[a] Provera [PF]

medroxyprogesterone acetate 10 mg tablet, 30

2321E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	17.96	19.17	[a] Ralovera [FZ]
			[B]6.70	24.66	19.17	[a] Provera [PF]

▪ MEDROXYPROGESTERONE

Restricted benefit
Endometriosis

medroxyprogesterone acetate 10 mg tablet, 100

2722G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	33.99	35.20	[a] Ralovera [FZ]
			[B]6.70	40.69	35.20	[a] Provera [PF]

Estren derivatives

▪ NORETHISTERONE

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

norethisterone 5 mg tablet, 30

2993M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	33.30	34.51	Primolut N [BN]

PROGESTOGENS AND ESTROGENS IN COMBINATION

Progestogens and estrogens, fixed combinations

▪ ESTRADIOL + DYDROGESTERONE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a

patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

estradiol 1 mg + dydrogesterone 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10142T NP	1	5	..	21.82	23.03	Femoston-Conti [GO]

▪ ESTRADIOL + NORETHISTERONE ACETATE

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

estradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch, 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8428N NP	‡1	5	..	22.14	23.35	Estalis continuous 50/250 [SZ]

estradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch, 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8427M NP	‡1	5	..	22.14	23.35	Estalis continuous 50/140 [SZ]

Progestogens and estrogens, sequential preparations

▪ ESTRADIOL (&) ESTRADIOL + DYDROGESTERONE

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

estradiol 2 mg tablet [14] (&) estradiol 2 mg + dydrogesterone 10 mg tablet [14], 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8244X NP	‡1	5	..	21.82	23.03	Femoston 2/10 [GO]

estradiol 1 mg tablet [14] (&) estradiol 1 mg + dydrogesterone 10 mg tablet [14], 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10146B NP	‡1	5	..	21.82	23.03	Femoston 1/10 [GO]

▪ NORETHISTERONE ACETATE + ESTRADIOL (&) ESTRADIOL

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

estradiol 50 microgram/24 hours patch [4] (&) estradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch [4], 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8426L NP	‡1	5	..	22.14	23.35	Estalis sequi 50/250 [SZ]

estradiol 50 microgram/24 hours patch [4] (&) estradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch [4], 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8425K NP	‡1	5	..	22.14	23.35	Estalis sequi 50/140 [SZ]

GONADOTROPINS AND OTHER OVULATION STIMULANTS

Gonadotropins

▪ FOLLITROPIN ALFA

Note Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomifene citrate and/or gonadorelin and failed to have conceived.

Note Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

Restricted benefit
Anovulatory infertility

Note Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Note Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Restricted benefit

Infertility

Clinical criteria:

- The condition must be due to hypogonadotrophic hypogonadism, **AND**
- The treatment must be following failure of 6 months' treatment with human chorionic gonadotrophin to achieve adequate spermatogenesis, **AND**
- The treatment must be administered with human chorionic gonadotrophin.

follitropin alfa 75 units (5.5 microgram)/0.125 mL injection, 5 x 0.125 mL injection devices

10865W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	1	..	*460.33	39.50	Bemfola [FX]

follitropin alfa 300 units (21.84 microgram)/0.5 mL injection, 0.5 mL cartridge

8713N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*369.22	39.50	Gonal-f Pen [SG]

follitropin alfa 225 units (16.5 microgram)/0.375 mL injection, 5 x 0.375 mL injection devices

10876K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	1	..	*1348.21	39.50	Bemfola [FX]

follitropin alfa 900 units (65.52 microgram)/1.5 mL injection, 1.5 mL cartridge

8715Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*733.65	39.50	Gonal-f Pen [SG]

follitropin alfa 150 units (11 microgram)/0.25 mL injection, 5 x 0.25 mL injection devices

10877L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	1	..	*915.85	39.50	Bemfola [FX]

follitropin alfa 450 units (32.76 microgram)/0.75 mL injection, 0.75 mL cartridge

8714P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*551.44	39.50	Gonal-f Pen [SG]

▪ FOLLITROPIN BETA

Note Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomifene citrate and/or gonadorelin and failed to have conceived.

Note Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

Restricted benefit

Anovulatory infertility

Note Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Note Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Restricted benefit

Infertility

Clinical criteria:

- The condition must be due to hypogonadotrophic hypogonadism, **AND**
- The treatment must be following failure of 6 months' treatment with human chorionic gonadotrophin to achieve adequate spermatogenesis, **AND**
- The treatment must be administered with human chorionic gonadotrophin.

follitropin beta 900 units/1.08 mL injection, 1.08 mL cartridge

8871X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*924.87	39.50	Puregon 900 IU/1.08 mL [MK]

follitropin beta 300 units/0.36 mL injection, 0.36 mL cartridge

8565T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*480.55	39.50	Puregon 300 IU/0.36 mL [MK]

follitropin beta 600 units/0.72 mL injection, 0.72 mL cartridge

8566W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*623.69	39.50	Puregon 600 IU/0.72 mL [MK]

▪ HUMAN CHORIONIC GONADOTROPHIN

Note Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

Restricted benefit

Anovulatory infertility

Note Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomifene citrate and/or gonadorelin and failed to have conceived.

Note Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Note Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Restricted benefit

Infertility

Population criteria:

- Patient must be male.

Clinical criteria:

- The condition must be due to hypogonadotrophic hypogonadism.

Restricted benefit

Infertility

Population criteria:

- Patient must be male.

Clinical criteria:

- The condition must be associated with isolated luteinising hormone deficiency.

Restricted benefit

Combined deficiency of human growth hormone and gonadotrophins

Population criteria:

- Patient must be male.

Clinical criteria:

- Patient must be one in whom the absence of secondary sexual characteristics indicates a lag in maturation.

Restricted benefit

Hypogonadism or delayed puberty

Population criteria:

- Patient must be male, **AND**
- Patient must be aged 16 years or older.

Clinical criteria:

- Patient must show clinical evidence of the condition, **AND**
- The treatment must not extend beyond 6 months.

human chorionic gonadotrophin 1500 units injection [3 vials] (&) inert substance diluent [3 x 1 mL vials], 1 pack

11148R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	45.04	39.50	Pregnyl [MK]

Ovulation stimulants, synthetic

▪ CLOMIFENE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Restricted benefit

Anovulatory infertility

Restricted benefit

Patients undergoing in-vitro fertilisation

clomifene citrate 50 mg tablet, 10

1211R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	35.52	36.73	Clomid [SW]

ANTIANDROGENS

Antiandrogens, plain

▪ CYPROTERONE

cyproterone acetate 100 mg tablet, 50

8019C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	66.87	39.50	[a] ANTERONE 100 [RW] [a] Cyprone 100 [AF] [a] Cyproterone AN [EA] [a] GenRx Cyproterone Acetate [GX]	[a] Cyprocur 100 [QA] [a] Cyprostat-100 [SY] [a] Cyproterone Sandoz [HX]
		[B]1.41	68.28	39.50	[a] Androcur-100 [BN]	

cyproterone acetate 50 mg tablet, 50

1270W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*82.69	39.50	[a] ANTERONE 50 [RW] [a] Cyprone [AF]	[a] Cyprocur 50 [QA] [a] Cyprostat [SY]

				[a] Cyproterone AN [EA] [a] Cyrotone [ER]	[a] Cyproterone Sandoz [HX] [a] GenRx Cyproterone Acetate [GX]
	[B]2.28	*84.97	39.50	[a] Androcur [BN]	

▪ CYPROTERONE

Caution This drug should not be used during pregnancy as it may result in feminisation of the male foetus.

Authority required (STREAMLINED)

5532

Moderate to severe androgenisation

Clinical criteria:

- The condition must not be indicated by acne alone, as this is not a sufficient indication of androgenisation.

Population criteria:

- Patient must be female.

Clinical criteria:

- Patient must not be pregnant.

cyproterone acetate 50 mg tablet, 20

1269T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	25.41	26.62	[a] ANTERONE 50 [RW] [a] Cyprone [AF] [a] Cyproterone AN [EA] [a] GenRx Cyproterone Acetate [GX]	[a] Cyprocur 50 [QA] [a] Cyprostat [SY] [a] Cyproterone Sandoz [HX]
	[B]2.40	27.81	26.62	[a] Androcur [BN]		

OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

Antigonadotropins and similar agents

▪ DANAZOL

Caution Pregnancy must be excluded prior to administration of this drug.

Authority required (STREAMLINED)

6293

Endometriosis

Clinical criteria:

- The condition must be visually proven.

Authority required (STREAMLINED)

6285

Hereditary angio-oedema

Authority required (STREAMLINED)

6259

Intractable primary menorrhagia

Clinical criteria:

- The treatment must be for the short-term (up to 6 months).

Note Treatment of this indication is limited to 6 months. See Australian Product Information

Authority required (STREAMLINED)

6242

Breast disease

Clinical criteria:

- The treatment must be for the short-term (up to 6 months), **AND**
- The condition must be severe benign (fibrocystic) breast disease; OR
- The condition must be mastalgia associated with severe symptomatic benign breast disease, **AND**
- The condition must be refractory to treatment with other drugs.

Note Treatment of this indication is limited to 6 months. See Australian Product Information

danazol 100 mg capsule, 100

1285P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	56.14	39.50	Azol 100 [AF]

danazol 200 mg capsule, 100

1287R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	80.66	39.50	Azol 200 [AF]

Progesterone receptor modulators

▪ MIFEPRISTONE (&) MISOPROSTOL

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

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

Authority required
Termination of an intra-uterine pregnancy
Clinical criteria:
- The condition must be an intra-uterine pregnancy of up to 63 days of gestation.

Treatment criteria:
- Must be treated by a prescriber who is registered with the MS 2 Step Prescribing Program.

mifepristone 200 mg tablet [1] (&) misoprostol 200 microgram tablet [4], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10211K	‡1	..	..	311.79	39.50	MS-2 Step [XH]

UROLOGICALS

UROLOGICALS

Drugs for urinary frequency and incontinence

OXYBUTYNIN

Restricted benefit
Detrusor overactivity

oxybutynin hydrochloride 5 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8039D NP	1	5	..	14.90	16.11	[a] Ditropan [SW]	[a] Oxybutynin Sandoz [SZ]

OXYBUTYNIN

Restricted benefit
Detrusor overactivity
Clinical criteria:
- Patient must be unable to tolerate oral oxybutynin; OR
- Patient must be unable to swallow oral oxybutynin.

oxybutynin 3.9 mg/24 hours patch, 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9454N NP	‡1	5	..	36.14	37.35	Oxytrol [GN]

PROPANTHELINE

Restricted benefit
Detrusor overactivity

propantheline bromide 15 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1953T NP	2	5	..	*27.65	28.86	Pro-Banthine [RW]

Other urologicals

BICARBONATE

sodium bicarbonate 840 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9470K NP	1	2	..	19.28	20.49	Sodibic [AS]

PHENOXYBENZAMINE

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

Restricted benefit
Phaeochromocytoma
Restricted benefit
Neurogenic urinary retention

phenoxybenzamine hydrochloride 10 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1166J NP	3	5	..	*997.75	39.50	Amdipharm Mercury (Australia) Pty Limited [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1862B NP	1	5	..	1103.27	39.50	Dibenyline [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9286R NP	1	5	..	1103.27	39.50	Dibenzyline [BZ]

DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY

Alpha-adrenoreceptor antagonists

▪ DUTASTERIDE + TAMSULOSIN

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6189

Benign prostatic hyperplasia

Clinical criteria:

- Patient must have lower urinary tract symptoms, **AND**
- Patient must have moderate to severe benign prostatic hyperplasia.

dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram modified release capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5490Y NP	1	5	..	31.97	33.18	Duodart 500ug/400ug [GK]

Testosterone-5-alpha reductase inhibitors

▪ DUTASTERIDE

Note Continuing Therapy Only:

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

Authority required (STREAMLINED)

6202

Benign prostatic hyperplasia

Clinical criteria:

- Patient must have lower urinary tract symptoms, **AND**
- Patient must have moderate to severe benign prostatic hyperplasia, **AND**
- The treatment must be in combination with an alpha-antagonist.

dutasteride 500 microgram capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5468T NP	1	5	..	27.76	28.97	[a] APO-Dutasteride [TX]	[a] Avodart [GK]

▪ SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

▪ PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

ACTH

▪ TETRACOSACTIDE (TETRACOSACTRIN)

tetracosactide (tetracosactrin) 1 mg/mL modified release injection, 1 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2832C	5	5	..	*449.95	39.50	Synacthen Depot 1 mg/1 mL [LM]

Thyrotropin

▪ THYROTROPIN ALFA

Restricted benefit

Ablation of thyroid remnant tissue

Clinical criteria:

- Patient must have undergone a thyroidectomy, **AND**
- The treatment must be in combination with radioactive iodine, **AND**
- Patient must not have a known metastatic disease.

thyrotropin alfa 900 microgram injection, 2 vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2700D	1	..	..	1802.84	39.50	Thyrogen [GZ]

POSTERIOR PITUITARY LOBE HORMONES

Vasopressin and analogues

▪ DESMOPRESSIN

Authority required (STREAMLINED)

5266

Cranial diabetes insipidus

desmopressin acetate 200 microgram tablet, 30

8662X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	5	..	*160.90	39.50	Minirin [FP]

desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations

8711L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*144.61	39.50	Minirin Nasal Spray [FP]

desmopressin acetate 100 microgram/mL nasal drops, 2.5 mL

2129C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5	5	..	*144.75	39.50	Minirin [FP]

▪ DESMOPRESSIN

Note Not to be used in preference to enuresis alarms.

Note Only one application per six months with no more than twice the maximum quantity will be authorised for the tablets.

Authority required (STREAMLINED)

5413

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be refractory to an enuresis alarm.

Authority required (STREAMLINED)

5295

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be one in whom an enuresis alarm is contraindicated.

The reason that an enuresis alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

desmopressin acetate 200 microgram tablet, 30

8663Y

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	61.03	39.50	Minirin [FP]

▪ DESMOPRESSIN

Caution Desmopressin nasal spray may be associated with an increased risk of hyponatraemia compared to the oral formulations.

Note Not to be used in preference to enuresis alarms.

Authority required (STREAMLINED)

5342

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be refractory to an enuresis alarm.

Authority required (STREAMLINED)

5267

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be one in whom an enuresis alarm is contraindicated.

The reason that an enuresis alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8712M NP	‡1	5	..	77.85	39.50	Minirin Nasal Spray [FP]

▪ DESMOPRESSIN

Note Not to be used in preference to enuresis alarms.

Note Only one application per six months will be authorised for the wafers. No more than twice the maximum quantity for the 120 micrograms wafers and no applications for increased maximum quantities for the 240 micrograms wafers will be authorised.

Authority required (STREAMLINED)

5412

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be refractory to an enuresis alarm.

Authority required (STREAMLINED)

5226

Primary nocturnal enuresis

Population criteria:

- Patient must be 6 years of age or older.

Clinical criteria:

- Patient must be one in whom an enuresis alarm is contraindicated.

The reason that an enuresis alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

desmopressin 120 microgram sublingual wafer, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9398P NP	1	5	..	66.73	39.50	Minirin Melt [FP]

desmopressin 240 microgram sublingual wafer, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8975J NP	1	5	..	105.68	39.50	Minirin Melt [FP]

HYPOTHALAMIC HORMONES

Gonadotropin-releasing hormones

▪ NAFARELIN

Restricted benefit

Endometriosis

Treatment Phase: Initial treatment, for up to 6 months

Clinical criteria:

- The condition must be visually proven.

Restricted benefit

Endometriosis

Treatment Phase: Subsequent treatment, for up to 6 months

Clinical criteria:

- The condition must be visually proven, **AND**
- The treatment must not be within 2 years of the end of the previous course of treatment with this drug, **AND**
- Patient must have had a recent bone density assessment.

The date of the bone density assessment must be recorded in the patient's medical records.

nafarelin 200 microgram/actuation nasal spray, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2962X	‡1	5	..	125.06	39.50	Synarel [PF]

▪ CORTICOSTEROIDS FOR SYSTEMIC USE

CORTICOSTEROIDS FOR SYSTEMIC USE, PLAIN

Mineralocorticoids

▪ FLUDROCORTISONE ACETATE

Note Continuing Therapy Only:

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

fludrocortisone acetate 100 microgram tablet, 100

1433K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	1	..	*44.89	39.50	Florinef [QA]

Glucocorticoids

▪ BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE

Restricted benefit
Local intra-articular or peri-articular infiltration
Restricted benefit
Keloid
Restricted benefit
Lichen planus hypertrophic

betamethasone (as sodium phosphate) 2.96 mg/mL + betamethasone (as acetate) 2.71 mg/mL injection, 5 x 1 mL ampoules

5034Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	27.25	28.46	Celestone Chronodose [MK]

▪ BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE

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

Restricted benefit
Alopecia areata
Restricted benefit
Local intra-articular or peri-articular infiltration
Restricted benefit
Granulomata
Clinical criteria:
- The condition must be dermal.

Restricted benefit
Keloid
Restricted benefit
Lichen planus hypertrophic
Restricted benefit
Lichen simplex chronicus
Restricted benefit
Chronic discoid lupus erythematosus
Restricted benefit
Necrobiosis lipoidica
Restricted benefit
Uveitis

betamethasone (as sodium phosphate) 2.96 mg/mL + betamethasone (as acetate) 2.71 mg/mL injection, 5 x 1 mL ampoules

2694T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	27.25	28.46	Celestone Chronodose [MK]

▪ CORTISONE

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

cortisone acetate 25 mg tablet, 60

1247P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	4	..	23.55	24.76	Cortate [AS]

cortisone acetate 5 mg tablet, 50

1246N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	4	..	18.42	19.63	Cortate [AS]

▪ DEXAMETHASONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical

practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

DEXAMETHASONE Tablet 500 micrograms, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1292B NP	1	4	..	13.19	14.40	Dexmethsone [AS]

DEXAMETHASONE Tablet 4 mg, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2507Y NP	1	4	..	16.29	17.50	Dexmethsone [AS]

▪ DEXAMETHASONE SODIUM PHOSPHATE

Note Shared Care Model:

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

DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 8 mg dexamethasone phosphate in 2 mL, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1291Y NP	1	1	..	26.10	27.31	[a] Dexamethasone Mylan [AF]	[a] Hospira Pty Limited [PF]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2509C NP	1	..	..	17.21	18.42	[a] Dexamethasone Mylan [AF]	[a] Hospira Pty Limited [PF]

▪ HYDROCORTISONE

Note Continuing Therapy Only:

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

hydrocortisone 4 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1499X NP	1	4	..	25.55	26.76	Hysone 4 [AF]

hydrocortisone 20 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1500Y NP	1	4	..	31.73	32.94	Hysone 20 [AF]

▪ HYDROCORTISONE SODIUM SUCCINATE

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1501B NP	2	..	..	*20.89	22.10	Solu-Cortef [PF]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3096Y NP	1	..	..	19.85	21.06	Solu-Cortef [PF]

▪ HYDROCORTISONE SODIUM SUCCINATE

Restricted benefit

For use in a hospital

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1510L NP	6	..	..	*40.51	39.50	Solu-Cortef [PF]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5118J DP	6	..	..	*40.51	39.50	Solu-Cortef [PF]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1511M NP	6	..	..	*63.67	39.50	Solu-Cortef [PF]

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

5119K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	6	..	..	*63.67	39.50	Solu-Cortef [PF]

▪ METHYLPREDNISOLONE

methylprednisolone Powder for injection 1 g (as sodium succinate), 1

5264C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	43.59	39.50	[a] Methylpred [AL]	[a] Methylprednisolone Alphapharm [AF]
						[a] Solu-Medrol [PF]	

▪ METHYLPREDNISOLONE

Restricted benefit

Local intra-articular or peri-articular infiltration

methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials

1928L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	22.47	23.68	[a] Depo-Nisolone [FZ]
			[B]2.61	25.08	23.68	[a] Depo-Medrol [PF]

▪ METHYLPREDNISOLONE

Note Pharmaceutical benefits that have the form methylprednisolone powder for injection 40 mg (as sodium succinate) and pharmaceutical benefits that have the form methylprednisolone powder for injection 40 mg (as sodium succinate) with diluent are equivalent for the purposes of substitution.

methylprednisolone 40 mg injection [5 vials] (&) inert substance diluent [5 x 1 mL vials], 1 pack

2981X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	26.52	27.73	[a] Solu-Medrol [PF]

methylprednisolone Powder for injection 40 mg (as sodium succinate), 5

5263B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	23.23	24.44	[a] Methylpred [AL]

▪ METHYLPREDNISOLONE

Restricted benefit

Local intra-articular or peri-articular infiltration

methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials

5148Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	22.47	23.68	[a] Depo-Nisolone [FZ]
			[B]2.61	25.08	23.68	[a] Depo-Medrol [PF]

▪ PREDNISOLONE

prednisolone 1 mg tablet, 100

3152X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	4	..	13.65	14.86	[a] Predsolone [LN]
			[B]1.00	14.65	14.86	[a] Panafcortelone [AS]

prednisolone 5 mg tablet, 60

1917X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	14.09	15.30	Panafcortelone [AS]	Solone [IA]

prednisolone 25 mg tablet, 30

1916W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	15.37	16.58	Panafcortelone [AS]	Solone [IA]

▪ PREDNISOLONE SODIUM PHOSPHATE

prednisolone (as sodium phosphate) 5 mg/mL oral liquid, 30 mL

8285C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	18.29	19.50	[a] PredMix [LN]
			[B]2.35	20.64	19.50	[a] Redipred [AS]

▪ PREDNISONE

prednisone 5 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1935W NP	1	4	..	14.00	15.21	Panafcort [AS]	Sone [IA]

prednisone 25 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1936X NP	1	4	..	15.43	16.64	Panafcort [AS]	Sone [IA]

prednisone 1 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1934T NP	1	4	..	13.60	14.81	[a] Predsone [LN]
			[B]1.00	14.60	14.81	[a] Panafcort [AS]

▪ TRIAMCINOLONE

Restricted benefit
Local intra-articular or peri-articular infiltration
Restricted benefit
Keloid
Restricted benefit
Lichen planus hypertrophic

triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5233K DP	1	..	..	27.25	28.46	Kenacort-A10 [QA]

▪ TRIAMCINOLONE

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

Restricted benefit
Alopecia areata
Restricted benefit
Local intra-articular or peri-articular infiltration
Restricted benefit
Granulomata
Clinical criteria:
- The condition must be dermal.

Restricted benefit
Keloid
Restricted benefit
Lichen planus hypertrophic
Restricted benefit
Lichen simplex chronicus
Restricted benefit
Chronic discoid lupus erythematosus
Restricted benefit
Necrobiosis lipoidica
Restricted benefit
Psoriasis

triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2990J NP	1	..	..	27.25	28.46	Kenacort-A10 [QA]

▪ THYROID THERAPY

THYROID PREPARATIONS

Thyroid hormones

▪ LIOTHYRONINE

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

Authority required (STREAMLINED)

6382

Thyroid cancer

Authority required (STREAMLINED)

6410

Hypothyroidism

Clinical criteria:

- The treatment must be for replacement therapy, **AND**
- Patient must have documented intolerance to thyroxine sodium; OR
- Patient must have documented resistance to thyroxine sodium.

Authority required (STREAMLINED)

6475

Hypothyroidism

Clinical criteria:

- The condition must be severe hypothyroidism, **AND**
- The treatment must be for initiation of therapy only.

liothyronine sodium 20 microgram tablet, 100

2318B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	77.69	39.50	Tertroxin [QA]

▪ THYROXINE

Note Continuing Therapy Only:

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

thyroxine sodium 75 microgram tablet, 200

9287T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	26.39	27.60	[a] Eutroxsig [FM]
			[B]1.98	28.37	27.60	[a] Oroxine [QA]

thyroxine sodium 50 microgram tablet, 200

2174K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	25.83	27.04	[a] Eutroxsig [FM]
			[B]1.91	27.74	27.04	[a] Oroxine [QA]

thyroxine sodium 100 microgram tablet, 200

2175L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	26.36	27.57	[a] Eutroxsig [FM]
			[B]1.92	28.28	27.57	[a] Oroxine [QA]

thyroxine sodium 200 microgram tablet, 200

2173J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	28.99	30.20	[a] Eutroxsig [FM]
			[B]1.93	30.92	30.20	[a] Oroxine [QA]

ANTITHYROID PREPARATIONS

Thiouracils

▪ PROPYLTHIOURACIL

Note Continuing Therapy Only:

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

propylthiouracil 50 mg tablet, 100

1955X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*47.89	39.50	PTU [PL]

Sulfur-containing imidazole derivatives

▪ CARBIMAZOLE

Note Continuing Therapy Only:

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

carbimazole 5 mg tablet, 100

1153Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*43.35	39.50	Carbimazol ARISTO [PQ]	Neo-Mercazole [GH]

PANCREATIC HORMONES

GLYCOGENOLYTIC HORMONES

Glycogenolytic hormones

GLUCAGON HYDROCHLORIDE

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

1449G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	50.97	39.50	GlucaGen Hypokit [NO]

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

5105Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	50.97	39.50	GlucaGen Hypokit [NO]

CALCIUM HOMEOSTASIS

PARATHYROID HORMONES AND ANALOGUES

Parathyroid hormones and analogues

TERIPARATIDE

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

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

Note Special Pricing Arrangements apply.

Authority required

Severe established osteoporosis

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist; OR
- Must be treated by a consultant physician.

Clinical criteria:

- Patient must be at very high risk of fracture, **AND**
- Patient must have a bone mineral density (BMD) T-score of -3.0 or less, **AND**
- Patient must have had 2 or more fractures due to minimal trauma, **AND**
- Patient must have experienced at least 1 symptomatic new fracture after at least 12 months continuous therapy with an anti-resorptive agent at adequate doses, **AND**
- The treatment must be the sole PBS-subsidised agent, **AND**
- The treatment must not exceed a lifetime maximum of 18 months therapy.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

If treatment with anti-resorptive therapy is contraindicated according to the relevant TGA-approved Product Information, details of the contraindication must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

If an intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use of one anti-resorptive agent, alternate anti-resorptive agents must be trialled so that the patient achieves the minimum requirement of 12 months continuous therapy**.** Details must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

Anti-resorptive therapies for osteoporosis and their adequate doses which will be accepted for the purposes of administering this restriction are alendronate sodium 10 mg per day or 70 mg once weekly, risedronate sodium 5 mg per day or 35 mg once weekly or 150 mg once monthly, raloxifene hydrochloride 60 mg per day (women only), denosumab 60 mg once every 6 months and zoledronic acid 5 mg per annum.

Details of prior anti-resorptive therapy, fracture history including the date(s), site(s), the symptoms associated with the fracture(s) which developed after at least 12 months continuous anti-resorptive therapy and the score of the qualifying BMD measurement must be provided at the time of application.

Note Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Authority required

Severe established osteoporosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- The treatment must not exceed a lifetime maximum of 18 months therapy.

Note Up to a maximum of 18 pens will be reimbursed through the PBS.

teriparatide 20 microgram/dose injection, 28 doses

9411H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	411.80	39.50	Forteo [LY]

ANTI-PARATHYROID AGENTS

Calcitonin preparations

▪ CALCITONIN SALMON (SALCATONIN)

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

Restricted benefit
Symptomatic Paget disease of bone
Restricted benefit
Hypercalcaemia
Clinical criteria:
- The treatment must be initiated in a hospital.

calcitonin salmon (salcatonin) 100 units/mL injection, 5 x 1 mL ampoules

2997R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*144.67	39.50	Miacalcic 100 [NV]

▪ ANTIINFECTIVES FOR SYSTEMIC USE

▪ ANTIBACTERIALS FOR SYSTEMIC USE

TETRACYCLINES

Tetracyclines

▪ DOXYCYCLINE

Note Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

doxycycline 100 mg tablet, 7

2709N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	12.55	13.76	[a] Doxsig [RW] [a] Doxylin 100 [AF]	[a] Doxycycline AN [EA]

doxycycline 100 mg tablet, 7

3321T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.55	13.76	[a] Doxsig [RW] [a] Doxylin 100 [AF]	[a] Doxycycline AN [EA]

doxycycline 100 mg tablet, 7

5082L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.55	13.76	[a] APO-Doxycycline [TX] [a] Doxycycline Sandoz [HX] [a] Terry White Chemists Doxycycline [TW]	[a] Chem mart Doxycycline [CH] [a] GenRx Doxycycline [GX]

doxycycline 100 mg tablet, 7

9105F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	12.55	13.76	[a] APO-Doxycycline [TX] [a] Doxycycline Sandoz [HX] [a] Terry White Chemists Doxycycline [TW]	[a] Chem mart Doxycycline [CH] [a] GenRx Doxycycline [GX]

doxycycline 100 mg modified release capsule, 7

2708M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	[B]1.54	14.09	13.76	[a] Mayne Pharma Doxycycline [YT]
			[B]2.96	15.51	13.76	[a] Doryx [YN]

doxycycline 100 mg modified release capsule, 7

3322W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	[B]1.54	14.09	13.76	[a] Mayne Pharma Doxycycline [YT]
			[B]2.96	15.51	13.76	[a] Doryx [YN]

▪ DOXYCYCLINE

Note Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

Restricted benefit

Urethritis

doxycycline 100 mg tablet, 21

10176N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.48	16.69	[a] Doxycycline AN [EA]	[a] Doxylin 100 [AF]

doxycycline 100 mg tablet, 21

1800R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.48	16.69	[a] APO-Doxycycline [TX]	[a] GenRx Doxycycline [GX]

doxycycline 100 mg tablet, 7

2714W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*15.46	16.67	[a] Doxsig [RW] [a] Doxylin 100 [AF]	[a] Doxycycline AN [EA]

doxycycline 100 mg tablet, 7

9108J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*15.46	16.67	[a] Chem mart Doxycycline [CH] [a] Terry White Chemists Doxycycline [TW]	[a] Doxycycline Sandoz [HX]

doxycycline 100 mg modified release capsule, 21

2715X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	[B]3.21	18.69	16.69	[a] Mayne Pharma Doxycycline [YT]
			[B]9.00	24.48	16.69	[a] Doryx [YN]

▪ DOXYCYCLINE

Note Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

Restricted benefit

Severe acne

doxycycline 100 mg tablet, 7

10779H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*16.95	18.16	[a] Doxsig [RW] [a] Doxylin 100 [AF]	[a] Doxycycline AN [EA]

doxycycline 100 mg tablet, 7

10781K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*16.95	18.16	[a] APO-Doxycycline [TX] [a] Doxycycline Sandoz [HX] [a] Terry White Chemists Doxycycline [TW]	[a] Chem mart Doxycycline [CH] [a] GenRx Doxycycline [GX]

doxycycline 100 mg modified release capsule, 7

10777F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	5	[B]6.16	*23.11	18.16	[a] Mayne Pharma Doxycycline [YT]
			[B]11.84	*28.79	18.16	[a] Doryx [YN]

▪ DOXYCYCLINE

Note Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

Restricted benefit

Pelvic inflammatory disease

doxycycline 100 mg tablet, 7

2702F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	..	..	*16.95	18.16	[a] Doxsig [RW] [a] Doxylin 100 [AF]	[a] Doxycycline AN [EA]

doxycycline 100 mg tablet, 7

9107H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	..	..	*16.95	18.16	[a] APO-Doxycycline [TX] [a] Doxycycline Sandoz [HX] [a] Terry White Chemists Doxycycline [TW]	[a] Chem mart Doxycycline [CH] [a] GenRx Doxycycline [GX]

doxycycline 100 mg modified release capsule, 7

2703G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	..	[B]6.16	*23.11	18.16	[a] Mayne Pharma Doxycycline [YT]
			[B]11.84	*28.79	18.16	[a] Doryx [YN]

▪ DOXYCYCLINE

Note Pharmaceutical benefits that have the forms doxycycline tablet 50 mg (as hydrochloride), doxycycline tablet 50 mg (as monohydrate) and doxycycline capsule: modified release 50 mg (as hydrochloride) are equivalent for the purposes of substitution.

Restricted benefit

Bronchiectasis

Population criteria:

- Patient must be aged 8 years or older.

Restricted benefit

Chronic bronchitis

Population criteria:

- Patient must be aged 8 years or older.

Restricted benefit

Severe acne

doxycycline 50 mg tablet, 25

2711Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.42	14.63	[a] Doxycycline AN [EA]	[a] Doxylin 50 [AF]

doxycycline 50 mg tablet, 25

9106G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.42	14.63	[a] APO-Doxycycline [TX] [a] Doxycycline Sandoz [HX] [a] GenRx Doxycycline [GX]	[a] Chem mart Doxycycline [CH] [a] Frakas [RW] [a] Terry White Chemists Doxycycline [TW]

doxycycline 50 mg modified release capsule, 25

2707L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	[B]2.59	16.01	14.63	[a] Mayne Pharma Doxycycline [YT]
			[B]5.01	18.43	14.63	[a] Doryx [YN]

▪ MINOCYCLINE

Caution There are concerns about the incidence of benign intracranial hypertension associated with this drug.

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

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

Restricted benefit

Severe acne

Clinical criteria:

- The condition must not be responding to other tetracyclines.

minocycline 50 mg tablet, 60

1616C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.59	19.80	[a] Akamin 50 [AF]
			[B]1.65	20.24	19.80	[a] Minomycin-50 [QA]

BETA-LACTAM ANTIBACTERIALS, PENICILLINS

Penicillins with extended spectrum

▪ AMOXICILLIN

amoxicillin 500 mg capsule, 20

1889K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	12.81	14.02	[a] Alphamox 500 [AF] [a] Amoxycillin generichealth 500 [GQ] [a] Amoxycillin Sandoz [SZ] [a] Cilamox [QA]	[a] Amoxycillin AN [EA] [a] Amoxycillin Ranbaxy [RA] [a] APO-Amoxycillin [TX] [a] Yomax 500 [DO]
			[B]3.76	16.57	14.02	[a] Amoxil [AS]	

amoxicillin 500 mg capsule, 20

3300Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.81	14.02	[a] Alphamox 500 [AF] [a] Amoxycillin generichealth 500 [GQ] [a] Amoxycillin Sandoz [SZ] [a] Cilamox [QA]	[a] Amoxycillin AN [EA] [a] Amoxycillin Ranbaxy [RA] [a] APO-Amoxycillin [TX] [a] Yomax 500 [DO]
			[B]3.76	16.57	14.02	[a] Amoxil [AS]	

amoxicillin 500 mg/5 mL powder for oral liquid, 100 mL

5225B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#15.63	17.20	Maxamox [SZ]

amoxicillin 500 mg/5 mL powder for oral liquid, 100 mL

8705E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	#15.63	17.20	Maxamox [SZ]

amoxicillin 100 mg/mL powder for oral liquid, 20 mL

1888J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	[S]0.53	#18.03	19.07	Amoxil [AS]

amoxicillin 100 mg/mL powder for oral liquid, 20 mL

3310F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	[S]0.53	#18.03	19.07	Amoxil [AS]

amoxicillin 250 mg capsule, 20

1884E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	12.49	13.70	[a] Alphamox 250 [AF] [a] Amoxycillin Ranbaxy [RA] [a] APO-Amoxycillin [TX] [a] Yomax 250 [DO]	[a] Amoxycillin AN [EA] [a] Amoxycillin Sandoz [SZ] [a] Cilamox [QA]
			[B]3.49	15.98	13.70	[a] Amoxil [AS]	

amoxicillin 250 mg capsule, 20

3301R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.49	13.70	[a] Alphamox 250 [AF] [a] Amoxycillin Ranbaxy [RA] [a] APO-Amoxycillin [TX] [a] Yomax 250 [DO]	[a] Amoxycillin AN [EA] [a] Amoxycillin Sandoz [SZ] [a] Cilamox [QA]
			[B]3.49	15.98	13.70	[a] Amoxil [AS]	

amoxicillin 125 mg/5 mL powder for oral liquid, 100 mL

1886G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#15.20	16.77	[a] Alphamox 125 [AF] [a] APO-Amoxycillin [TX]	[a] Amoxycillin Sandoz [SZ] [a] Ranmoxy [RA]
			[B]3.46	#18.66	16.77	[a] Amoxil [AS]	

amoxicillin 125 mg/5 mL powder for oral liquid, 100 mL

3302T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#15.20	16.77	[a] Alphamox 125 [AF] [a] APO-Amoxycillin [TX]	[a] Amoxycillin Sandoz [SZ] [a] Ranmoxy [RA]
			[B]3.46	#18.66	16.77	[a] Amoxil [AS]	

amoxicillin 250 mg/5 mL powder for oral liquid, 100 mL

1887H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#15.53	17.10	[a] Alphamox 250 [AF] [a] APO-Amoxycillin [TX]	[a] Amoxycillin Sandoz [SZ] [a] Cilamox [QA]

						[a] Ranmoxy [RA]	
			[B]3.56	#19.09	17.10	[a] Amoxil Forte [AS]	

amoxicillin 250 mg/5 mL powder for oral liquid, 100 mL

3393N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#15.53	17.10	[a] Alphamox 250 [AF]	[a] Amoxycillin Sandoz [SZ]
						[a] APO-Amoxycillin [TX]	[a] Cilamox [QA]
						[a] Ranmoxy [RA]	
			[B]3.56	#19.09	17.10	[a] Amoxil Forte [AS]	

▪ AMOXICILLIN

Restricted benefit

Chronic bronchitis

Clinical criteria:

- Patient must have acute exacerbations of the condition.

amoxicillin 1 g tablet, 14

8581P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.67	13.88	[a] Amoxycillin Sandoz [BG]
			[B]1.08	13.75	13.88	[a] Maxamox [SZ]

▪ AMOXICILLIN

Authority required

Infection suspected or proven to be due to a susceptible organism

Clinical criteria:

- The treatment must be for patients who require a liquid formulation and in whom the syrup formulations are unsuitable.

amoxicillin 100 mg/mL powder for oral liquid, 20 mL

9714G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	#18.03	19.60	Amoxil [AS]

▪ AMPICILLIN

ampicillin 500 mg injection, 5 vials

2390T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	16.05	17.26	Austrapen [AL]

ampicillin 500 mg injection, 5 vials

3313J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	16.05	17.26	Austrapen [AL]

ampicillin 1 g injection, 5 vials

2977Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	17.23	18.44	[a] Ampicyn [AF]	[a] Austrapen [AL]

ampicillin 1 g injection, 5 vials

3314K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	17.23	18.44	[a] Ampicyn [AF]	[a] Austrapen [AL]

Beta-lactamase sensitive penicillins

▪ BENZATHINE BENZYLPENICILLIN

BENZATHINE BENZYLPENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10

2267H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	309.22	39.50	Bicillin L-A [PF]

BENZATHINE BENZYLPENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10

5027N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	309.22	39.50	Bicillin L-A [PF]

▪ BENZYLPENICILLIN

benzylpenicillin 600 mg injection, 1 vial

1775K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	10	1	..	*61.35	39.50	BenPen [CS]

benzylpenicillin 600 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3398W DP	10	..	..	*61.35	39.50	BenPen [CS]

benzylpenicillin 3 g injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2647H NP	10	..	..	*97.95	39.50	BenPen [CS]

benzylpenicillin 3 g injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3399X DP	10	..	..	*97.95	39.50	BenPen [CS]

▪ PHENOXYMETHYLPENICILLIN

phenoxymethylpenicillin 250 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1789E NP	1	..	..	15.21	16.42	Cilicaine VK [FM]	LPV [IA]

phenoxymethylpenicillin 250 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3363B DP	1	..	..	15.21	16.42	Cilicaine VK [FM]	LPV [IA]

phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5012T DP	2	..	..	*24.29	25.50	Cilicaine V [FM]

phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9143F NP	2	1	..	*24.29	25.50	Cilicaine V [FM]

phenoxymethylpenicillin 250 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1787C NP	2	..	..	*15.35	16.56	Aspecillin VK [QA]

phenoxymethylpenicillin 250 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3360W DP	2	..	..	*15.35	16.56	Aspecillin VK [QA]

phenoxymethylpenicillin 125 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5024K DP	2	..	..	*#20.56	22.13	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 125 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8976K NP	2	1	..	*#20.56	22.13	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 500 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3028J NP	2	..	..	*17.39	18.60	Aspecillin VK [QA]

phenoxymethylpenicillin 500 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3361X DP	2	..	..	*17.39	18.60	Aspecillin VK [QA]

phenoxymethylpenicillin 500 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2965C NP	1	..	..	17.22	18.43	Cilicaine VK [FM]	LPV [IA]

phenoxymethylpenicillin 500 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3364C DP	1	..	..	17.22	18.43	Cilicaine VK [FM]	LPV [IA]

phenoxymethylpenicillin 250 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5029Q DP	2	..	..	*#22.80	24.37	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 250 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8977L NP	2	1	..	*#22.80	24.37	Phenoxymethylpenicillin-AFT [AE]

▪ PHENOXYMETHYLPENICILLIN

Restricted benefit

Recurrent streptococcal infections (including rheumatic fever)

Clinical criteria:

- The treatment must be for prophylaxis.

phenoxymethylpenicillin 250 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1705R NP	1	5	..	15.21	16.42	Cilicaine VK [FM]	LPV [IA]

phenoxymethylpenicillin 250 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1703P NP	2	5	..	*15.35	16.56	Aspecillin VK [QA]

▪ PROCAINE BENZYLPENICILLIN (PROCAINE PENICILLIN)

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1794K NP	1	..	..	85.18	39.50	Cilicaine [QA]

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

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3371K DP	1	..	..	85.18	39.50	Cilicaine [QA]

Beta-lactamase resistant penicillins

▪ DICLOXACILLIN

Restricted benefit

Serious staphylococcal infection

dicloxacillin 250 mg capsule, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5096F DP	1	..	..	16.60	17.81	Distaph 250 [AF]

dicloxacillin 500 mg capsule, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5097G DP	1	..	..	20.73	21.94	Distaph 500 [AF]

▪ DICLOXACILLIN

Restricted benefit

Serious staphylococcal infection

dicloxacillin 250 mg capsule, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8121K NP MW	1	..	..	16.60	17.81	Distaph 250 [AF]

dicloxacillin 500 mg capsule, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8122L NP MW	1	..	..	20.73	21.94	Distaph 500 [AF]

▪ DICLOXACILLIN

Authority required (STREAMLINED)

6188

Osteomyelitis

dicloxacillin 500 mg capsule, 24

10790X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*30.37	31.58	Distaph 500 [AF]

▪ FLUCLOXACILLIN

Caution Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Note Pharmaceutical benefits that have the form flucloxacillin 1 g injection in a pack size of 5 can be substituted for a pack size of 10 in the case of a shortage.

flucloxacillin 1 g injection, 10 vials

10605E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	0.5	1	..	*23.50	24.71	[a] Hospira Pty Limited [PF]

flucloxacillin 1 g injection, 10 vials

10609J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	0.5	..	..	*23.50	24.71	[a] Hospira Pty Limited [PF]

flucloxacillin 1 g injection, 5 vials

1525G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	19.67	20.88	[a] Flucil [AS]

flucloxacillin 1 g injection, 5 vials

5095E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	19.67	20.88	[a] Flucil [AS]

▪ FLUCLOXACILLIN

Caution Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Restricted benefit

Serious staphylococcal infection

flucloxacillin 500 mg capsule, 24

1527J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	19.78	20.99	[a] APO-Flucloxacillin [TX] [a] Staphylex 500 [AF]	[a] Flopen [AS]

flucloxacillin 250 mg capsule, 24

1526H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	15.24	16.45	[a] APO-Flucloxacillin [TX] [a] Staphylex 250 [AF]	[a] Flopen [AS]

▪ FLUCLOXACILLIN

Caution Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Restricted benefit

Serious staphylococcal infection

flucloxacillin 125 mg/5 mL powder for oral liquid, 100 mL

5257Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#19.95	21.52	Flucil [LN]

flucloxacillin 500 mg capsule, 24

5091Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	19.78	20.99	[a] APO-Flucloxacillin [TX] [a] Staphylex 500 [AF]	[a] Flopen [AS]

flucloxacillin 250 mg/5 mL powder for oral liquid, 100 mL

5258R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#23.02	24.59	Flucil [LN]

flucloxacillin 250 mg capsule, 24

5090X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	15.24	16.45	[a] APO-Flucloxacillin [TX] [a] Staphylex 250 [AF]	[a] Flopen [AS]

▪ FLUCLOXACILLIN

Caution Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Restricted benefit

Serious staphylococcal infection

flucloxacillin 125 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9149M NP	‡1	1	..	#19.95	21.52	Flucil [LN]

flucloxacillin 250 mg/5 mL powder for oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9150N NP	‡1	1	..	#23.02	24.59	Flucil [LN]

▪ FLUCLOXACILLIN

Caution Severe cholestatic jaundice has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Authority required (STREAMLINED)

6169

Osteomyelitis

flucloxacillin 500 mg capsule, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10788T	2	1	..	*28.47	29.68	[a] APO-Flucloxacillin [TX] [a] Staphylex 500 [AF]	[a] Flopen [AS]

Combinations of penicillins, incl. beta-lactamase inhibitors

▪ AMOXICILLIN + CLAVULANIC ACID

Caution Hepatotoxicity has been reported with this drug.

Restricted benefit

Infection where resistance to amoxycillin is suspected

Restricted benefit

Infections where resistance to amoxycillin is proven

amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL powder for oral liquid, 60 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8319W NP	‡1	1	..	#15.86	17.43	[a] APO-Amoxycillin and Clavulanic Acid 400/57 [TX]	[a] Curam Duo [SZ]
			[B]4.84	#20.70	17.43	[a] Augmentin Duo 400 [AS]	

amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8254K NP	1	1	..	13.86	15.07	[a] AlphaClav Duo Forte [AF] [a] AMOXICLAV AMNEAL 875/125 [ED] [a] AmoxyClav generichealth 875/125 [HQ] [a] Chem mart Amoxycillin and Clavulanic Acid [CH] [a] Curam Duo Forte 875/125 [SZ] [a] Terry White Chemists Amoxycillin and Clavulanic Acid [TW]	[a] AMCLAVOX DUO FORTE 875/125 [RW] [a] Amoxyclav AN 875/125 [EA] [a] APO-Amoxycillin and Clavulanic Acid [TX] [a] Clavam 875 mg/125 mg [CR] [a] Moxiclav Duo Forte 875/125 [QA]
			[B]6.24	20.10	15.07	[a] Augmentin Duo forte [AS]	

amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1891M NP MW	1	1	..	13.56	14.77	[a] AlphaClav Duo [AF] [a] AMOXICLAV AMNEAL 500/125 [ED] [a] APO-Amoxycillin/ Clavulanic Acid 500/125 [TX] [a] Moxiclav Duo 500/125 [QA]	[a] AMCLAVOX DUO 500/125 [RW] [a] Amoxyclav AN 500/125 [EA] [a] Curam Duo 500/125 [SZ]
			[B]4.87	18.43	14.77	[a] Augmentin Duo [AS]	

amoxicillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL powder for oral liquid, 75 mL

1892N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#15.54	17.11	[a] APO-Amoxycillin and Clavulanic Acid 125/31.25 [TX]	[a] Curam [SZ]

▪ AMOXICILLIN + CLAVULANIC ACID

Caution Hepatotoxicity has been reported with this drug.

Restricted benefit

Infection where resistance to amoxycillin is suspected

Restricted benefit

Infections where resistance to amoxycillin is proven

amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL powder for oral liquid, 60 mL

5011R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#15.86	17.43	[a] APO-Amoxycillin and Clavulanic Acid 400/57 [TX]	[a] Curam Duo [SZ]
			[B]4.84	#20.70	17.43	[a] Augmentin Duo 400 [AS]	

amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

5006L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.86	15.07	[a] AlphaClav Duo Forte [AF]	[a] AMCLAVOX DUO FORTE 875/125 [RW]
						[a] AMOXICLAV AMNEAL 875/125 [ED]	[a] Amoxyclav AN 875/125 [EA]
						[a] AmoxyClav generichealth 875/125 [HQ]	[a] APO-Amoxycillin and Clavulanic Acid [TX]
						[a] Chem mart Amoxycillin and Clavulanic Acid [CH]	[a] Clavam 875 mg/125 mg [CR]
						[a] Curam Duo Forte 875/125 [SZ]	[a] Moxiclav Duo Forte 875/125 [QA]
						[a] Terry White Chemists Amoxycillin and Clavulanic Acid [TW]	
			[B]6.24	20.10	15.07	[a] Augmentin Duo forte [AS]	

amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10

5008N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.56	14.77	[a] AlphaClav Duo [AF]	[a] AMCLAVOX DUO 500/125 [RW]
						[a] AMOXICLAV AMNEAL 500/125 [ED]	[a] Amoxyclav AN 500/125 [EA]
						[a] APO-Amoxycillin/ Clavulanic Acid 500/125 [TX]	[a] Curam Duo 500/125 [SZ]
						[a] Moxiclav Duo 500/125 [QA]	
			[B]4.87	18.43	14.77	[a] Augmentin Duo [AS]	

amoxicillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL powder for oral liquid, 75 mL

5009P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#15.54	17.11	[a] APO-Amoxycillin and Clavulanic Acid 125/31.25 [TX]	[a] Curam [SZ]

OTHER BETA-LACTAM ANTIBACTERIALS

First-generation cephalosporins

▪ CEFALEXIN

cefalexin 500 mg capsule, 20

3119E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	12.95	14.16	[a] APO-Cephalexin [TX]	[a] Cefalexin Sandoz [SZ]
						[a] Cephalex 500 [CR]	[a] Cephalexin AN [EA]
						[a] Cephalexin generichealth [GQ]	[a] Ibilex 500 [AF]
						[a] Rancef [RA]	
			[B]5.47	18.42	14.16	[a] Keflex [AS]	

cefalexin 500 mg capsule, 20

3318P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.95	14.16	[a] APO-Cephalexin [TX]	[a] Cefalexin Sandoz [SZ]
						[a] Cephalex 500 [CR]	[a] Cephalexin AN [EA]
						[a] Cephalexin generichealth [GQ]	[a] Ibilex 500 [AF]
						[a] Rancef [RA]	

			[B]5.47	18.42	14.16	[a] Keflex [AS]	

cefalexin 250 mg capsule, 20

3058Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	12.80	14.01	[a] APO-Cephalexin [TX] [a] Cephalex 250 [CR] [a] Ibilex 250 [AF]	[a] Cefalexin Sandoz [SZ] [a] Cephalexin AN [EA] [a] Rancef [RA]
			[B]3.76	16.56	14.01	[a] Keflex [AS]	

cefalexin 250 mg capsule, 20

3317N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.80	14.01	[a] APO-Cephalexin [TX] [a] Cephalex 250 [CR] [a] Ibilex 250 [AF]	[a] Cefalexin Sandoz [SZ] [a] Cephalexin AN [EA] [a] Rancef [RA]
			[B]3.76	16.56	14.01	[a] Keflex [AS]	

cefalexin 125 mg/5 mL powder for oral liquid, 100 mL

3094W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#15.78	17.35	[a] Cefalexin Sandoz [SZ]	[a] Ibilex 125 [AF]
			[B]4.15	#19.93	17.35	[a] Keflex [AS]	

cefalexin 125 mg/5 mL powder for oral liquid, 100 mL

3319Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#15.78	17.35	[a] Cefalexin Sandoz [SZ]	[a] Ibilex 125 [AF]
			[B]4.15	#19.93	17.35	[a] Keflex [AS]	

cefalexin 250 mg/5 mL powder for oral liquid, 100 mL

3095X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#16.08	17.65	[a] Cefalexin Sandoz [SZ]	[a] Ibilex 250 [AF]
			[B]5.69	#21.77	17.65	[a] Keflex [AS]	

cefalexin 250 mg/5 mL powder for oral liquid, 100 mL

3320R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#16.08	17.65	[a] Cefalexin Sandoz [SZ]	[a] Ibilex 250 [AF]
			[B]5.69	#21.77	17.65	[a] Keflex [AS]	

▪ CEFALEXIN

Authority required (STREAMLINED)

6188

Osteomyelitis

cefalexin 500 mg capsule, 20

10778G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	1	..	*14.81	16.02	[a] APO-Cephalexin [TX] [a] Cephalex 500 [CR] [a] Cephalexin generichealth [GQ] [a] Rancef [RA]	[a] Cefalexin Sandoz [SZ] [a] Cephalexin AN [EA] [a] Ibilex 500 [AF]
			[B]10.94	*25.75	16.02	[a] Keflex [AS]	

▪ CEFALEXIN

Authority required (STREAMLINED)

4243

Prophylaxis of urinary tract infection

cefalexin 250 mg capsule, 20

2655R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	2	..	*14.51	15.72	[a] APO-Cephalexin [TX] [a] Cephalex 250 [CR] [a] Ibilex 250 [AF]	[a] Cefalexin Sandoz [SZ] [a] Cephalexin AN [EA] [a] Rancef [RA]
			[B]7.52	*22.03	15.72	[a] Keflex [AS]	

▪ CEFAZOLIN

Restricted benefit

Cellulitis

cefazolin 500 mg injection, 5 vials

5477G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*17.39	18.60	Cefazolin-AFT [AE]

cefazolin 2 g injection, 1 vial

5479J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*38.85	39.50	Cephazolin Alphapharm [AF]

▪ CEFAZOLIN

Note For item codes 5478H and 1799Q, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

Restricted benefit
Cellulitis

cefazolin 1 g injection, 5 vials

1799Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*20.87	22.08	[a] Cefazolin-AFT [AE]	[a] Hospira Cefazolin Sodium [PF]

cefazolin 1 g injection, 10 vials

5478H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	20.87	22.08	[a] Cefazolin Sandoz [SZ]

▪ CEFAZOLIN

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

Restricted benefit
Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent
Restricted benefit
Septicaemia, suspected
Restricted benefit
Septicaemia, proven

cefazolin 500 mg injection, 5 vials

1256D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*17.39	18.60	Cefazolin-AFT [AE]

cefazolin 2 g injection, 1 vial

9326W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	10	..	..	*38.85	39.50	Cephazolin Alphapharm [AF]

▪ CEFAZOLIN

Note For item codes 1257E and 1797N, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

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

Restricted benefit
Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent
Restricted benefit
Septicaemia, suspected
Restricted benefit
Septicaemia, proven

cefazolin 1 g injection, 5 vials

1797N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*20.87	22.08	[a] Cefazolin-AFT [AE]	[a] Hospira Cefazolin Sodium [PF]

cefazolin 1 g injection, 10 vials

1257E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	20.87	22.08	[a] Cefazolin Sandoz [SZ]

▪ CEPHALOTHIN

cephalothin 1 g injection, 10 vials

2964B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	25.56	26.77	Hospira Pty Limited [PF]

cephalothin 1 g injection, 10 vials

3376Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	25.56	26.77	Hospira Pty Limited [PF]

Second-generation cephalosporins

▪ CEFACLOR

Caution Serum sickness-like reactions have been reported with this drug, especially in children.

cefaclor 125 mg/5 mL powder for oral liquid, 100 mL

2460L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	1	..	#17.16	18.73	[a] Aclor 125 [QA] [a] Keflor [AF]	[a] APO-Cefaclor [TX]
			[B]5.10	#22.26	18.73	[a] Ceclor [AS]	

cefaclor 125 mg/5 mL powder for oral liquid, 100 mL

5046N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#17.16	18.73	[a] Aclor 125 [QA] [a] Keflor [AF]	[a] APO-Cefaclor [TX]
			[B]5.10	#22.26	18.73	[a] Ceclor [AS]	

cefaclor 250 mg/5 mL powder for oral liquid, 75 mL

2461M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	1	..	#17.38	18.95	[a] Aclor 250 [QA] [a] Keflor [AF]	[a] APO-Cefaclor [TX]
			[B]5.31	#22.69	18.95	[a] Ceclor [AS]	

cefaclor 250 mg/5 mL powder for oral liquid, 75 mL

5047P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#17.38	18.95	[a] Aclor 250 [QA] [a] Keflor [AF]	[a] APO-Cefaclor [TX]
			[B]5.31	#22.69	18.95	[a] Ceclor [AS]	

cefaclor 375 mg modified release tablet, 10

1169M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	14.85	16.06	[a] APO-Cefaclor CD [TX] [a] Karlor CD [LN]	[a] Cefaclor GH [GQ] [a] Keflor CD [AF]
			[B]6.26	21.11	16.06	[a] Ceclor CD [AS]	

cefaclor 375 mg modified release tablet, 10

5045M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	14.85	16.06	[a] APO-Cefaclor CD [TX] [a] Karlor CD [LN]	[a] Cefaclor GH [GQ] [a] Keflor CD [AF]
			[B]6.26	21.11	16.06	[a] Ceclor CD [AS]	

▪ CEFUROXIME

cefuroxime 250 mg tablet, 20

11227X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	25.50	26.71	Zinnat [AS]

cefuroxime 250 mg tablet, 20

11228Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	25.50	26.71	Zinnat [AS]

cefuroxime 125 mg/5 mL powder for oral liquid, 100 mL

11191B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#26.11	27.68	Zinnat [AS]

cefuroxime 125 mg/5 mL powder for oral liquid, 100 mL

11192C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	#26.11	27.68	Zinnat [AS]

cefuroxime 250 mg tablet, 14

5052X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	21.18	22.39	[a] Pharmacor Cefuroxime [CR]	[a] Zinnat [AS]

cefuroxime 250 mg tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8292K	1	1	..	21.18	22.39	[a] Pharmacor Cefuroxime [CR]	[a] Zinnat [AS]

CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2002J DP	‡1	..	..	#22.42	23.99	Zinnat [AS]

CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5499K	‡1	1	..	#22.42	23.99	Zinnat [AS]

Third-generation cephalosporins

▪ CEFOTAXIME

Restricted benefit

Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

CEFOTAXIME Powder for injection 1 g, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1768C DP	1	..	..	23.88	25.09	Hospira Pty Limited [PF]

▪ CEFOTAXIME

Restricted benefit

Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

CEFOTAXIME Powder for injection 2 g, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1769D DP	1	..	..	34.74	35.95	Hospira Pty Limited [PF]

▪ CEFOTAXIME

Note Shared Care Model:

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

Restricted benefit

Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

CEFOTAXIME Powder for injection 2 g, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1759N NP	1	..	..	34.74	35.95	Hospira Pty Limited [PF]

CEFOTAXIME Powder for injection 1 g, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1758M NP	1	..	..	23.88	25.09	Hospira Pty Limited [PF]

▪ CEFTRIAXONE

Restricted benefit

Gonorrhoea

ceftriaxone 500 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9058R NP	1	..	..	12.15	13.36	Ceftriaxone-AFT [AE]

▪ CEFTRIAXONE

Note Shared Care Model:

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

Restricted benefit

Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit
Septicaemia, proven

ceftriaxone 500 mg injection, 1 vial

1783W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5	..	..	*16.40	17.61	Ceftriaxone-AFT [AE]

NP

▪ CEFTRIAXONE

Note Pharmaceutical benefits that have the form ceftriaxone 2 g injection, 1 vial and pharmaceutical benefits that have the form ceftriaxone 2 g injection, 5 vials are equivalent for the purposes of substitution.

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

Restricted benefit
Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit
Septicaemia, suspected

Restricted benefit
Septicaemia, proven

ceftriaxone 2 g injection, 1 vial

1785Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5	..	..	*22.25	23.46	[a] Ceftriaxone-AFT [AE]

NP

ceftriaxone 2 g injection, 5 vials

11169W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	22.22	23.43	[a] Ceftriaxone Alphapharm [AF]

NP

▪ CEFTRIAXONE

Note For item codes 1784X and 1788D, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

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

Restricted benefit
Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit
Septicaemia, suspected

Restricted benefit
Septicaemia, proven

CEFTRIAXONE Powder for injection 1 g, 5

1788D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	22.11	23.32	[a] Ceftriaxone Alphapharm [AF]

NP

ceftriaxone 1 g injection, 1 vial

1784X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5	..	..	*22.10	23.31	[a] Ceftriaxone-AFT [AE] [a] Hospira Ceftriaxone [PF]	[a] Ceftriaxone Sandoz [SZ]

NP

Fourth-generation cephalosporins

▪ CEFEPIME

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

Authority required
Febrile neutropenia

CEFEPIME Powder for injection 1 g (as hydrochloride), 1

8315P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10	..	..	*79.35	39.50	[a] Cefepime-AFT [AE] [a] Cefepime Kabi [PK] [a] Omegapharm Pty Ltd [OE]	[a] Cefepime Alphapharm [AF] [a] DBL Cefepime [PF]

NP

CEFEPIME Powder for injection 2 g (as hydrochloride), 1

8316Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	..	..	*129.55	39.50	[a] Cefepime-AFT [AE] [a] Cefepime Kabi [PK] [a] Omegapharm Pty Ltd [OE]	[a] Cefepime Alphapharm [AF] [a] DBL Cefepime [PF]

SULFONAMIDES AND TRIMETHOPRIM

Trimethoprim and derivatives

▪ TRIMETHOPRIM

trimethoprim 300 mg tablet, 7

2922T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.79	14.00	[a] Alprim [AF]
			[B]3.68	16.47	14.00	[a] Triprim [RW]

▪ TRIMETHOPRIM

Authority required (STREAMLINED)

4243

Prophylaxis of urinary tract infection

trimethoprim 300 mg tablet, 7

2666H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	2	..	*14.49	15.70	[a] Alprim [AF]
			[B]7.36	*21.85	15.70	[a] Triprim [RW]

▪ TRIMETHOPRIM

Restricted benefit

Prostatitis

trimethoprim 300 mg tablet, 7

10785P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*17.91	19.12	[a] Alprim [AF]
			[B]14.72	*32.63	19.12	[a] Triprim [RW]

Combinations of sulfonamides and trimethoprim, incl. derivatives

▪ TRIMETHOPRIM + SULFAMETHOXAZOLE

Caution There is an increased risk of severe adverse reactions with this combination in the elderly.

trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10

2951H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.98	14.19	[a] Resprim Forte [AF]
			[B]2.17	15.15	14.19	[a] Bactrim DS [RO]
			[B]4.17	17.15	14.19	[a] Septrin Forte [RW]

trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10

3390K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	12.98	14.19	[a] Resprim Forte [AF]
			[B]2.17	15.15	14.19	[a] Bactrim DS [RO]
			[B]4.17	17.15	14.19	[a] Septrin Forte [RW]

trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL

3103H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	13.27	14.48	Bactrim [RO]
			[B]5.69	18.96	14.48	Septrin [RW]

trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL

3391L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	13.27	14.48	Bactrim [RO]
			[B]5.69	18.96	14.48	Septrin [RW]

▪ TRIMETHOPRIM + SULFAMETHOXAZOLE

Caution There is an increased risk of severe adverse reactions with this combination in the elderly.

Authority required (STREAMLINED)

6201

Prophylaxis of Pneumocystis jiroveci pneumonia

trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10

10784N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	2	..	*16.75	17.96	[a] Resprim Forte [AF]
			[B]6.51	*23.26	17.96	[a] Bactrim DS [RO]
			[B]12.51	*29.26	17.96	[a] Septrin Forte [RW]

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

▪ AZITHROMYCIN

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

Restricted benefit
Trachoma

azithromycin 500 mg tablet, 2

8336R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	15.37	16.58	[a] APO-Azithromycin [TX] [a] Azithromycin Sandoz [SZ] [a] Terry White Chemists Azithromycin [TW]	[a] Azithromycin Mylan [AF] [a] Chem mart Azithromycin [CH] [a] Zithromax [PF]

azithromycin 200 mg/5 mL powder for oral liquid, 15 mL

8201P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	#26.26	27.83	Zithromax [PF]

▪ AZITHROMYCIN

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

Restricted benefit
Urethritis
Clinical criteria:
- The condition must be uncomplicated and due to Chlamydia trachomatis.

Restricted benefit
Cervicitis
Clinical criteria:
- The condition must be uncomplicated and due to Chlamydia trachomatis.

azithromycin 500 mg tablet, 2

8200N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.37	16.58	[a] APO-Azithromycin [TX] [a] Azithromycin Sandoz [SZ] [a] Terry White Chemists Azithromycin [TW]	[a] Azithromycin Mylan [AF] [a] Chem mart Azithromycin [CH] [a] Zithromax [PF]

▪ CLARITHROMYCIN

clarithromycin 250 mg tablet, 14

8318T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	14.05	15.26	[a] APO-Clarithromycin [TX] [a] Clarac [ED] [a] Clarithro 250 [RW] [a] Clarithromycin Sandoz [SZ] [a] Terry White Chemists Clarithromycin [TW]	[a] Chem mart Clarithromycin [CH] [a] Clarihexal [HX] [a] Clarithromycin AN [EA] [a] Kalixocin [AF]
			[B]3.49	17.54	15.26	[a] Klacid [GO]	

▪ CLARITHROMYCIN

Restricted benefit
Bordetella pertussis
Restricted benefit
Atypical mycobacterial infections

clarithromycin 250 mg/5 mL powder for oral liquid, 50 mL

9192T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	#29.93	31.50	Klacid [GO]

▪ ERYTHROMYCIN

erythromycin 250 mg enteric capsule, 25

1404X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	15.87	17.08	[a] Mayne Pharma Erythromycin [YT]
			[B]2.53	18.40	17.08	[a] Eryc [YN]

erythromycin 250 mg enteric capsule, 25

3325B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	15.87	17.08	[a] Mayne Pharma Erythromycin [YT]
			[B]2.53	18.40	17.08	[a] Eryc [YN]

▪ ERYTHROMYCIN

Authority required (STREAMLINED)

6160

Severe acne

Clinical criteria:

- The condition must be one in which tetracycline therapy is inappropriate.

erythromycin 250 mg enteric capsule, 25

10780J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*20.65	21.86	[a] Mayne Pharma Erythromycin [YT]
			[B]5.06	*25.71	21.86	[a] Eryc [YN]

▪ ERYTHROMYCIN ETHYLSUCCINATE

erythromycin (as ethylsuccinate) 200 mg/5 mL powder for oral liquid, 100 mL

2424N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	#18.62	20.19	[a] E-Mycin 200 [AF]
			[B]2.36	#20.98	20.19	[a] E.E.S. 200 [GH]

erythromycin (as ethylsuccinate) 200 mg/5 mL powder for oral liquid, 100 mL

3334L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#18.62	20.19	[a] E-Mycin 200 [AF]
			[B]2.36	#20.98	20.19	[a] E.E.S. 200 [GH]

erythromycin (as ethylsuccinate) 400 mg tablet, 25

2750R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	15.99	17.20	E-Mycin [AF]

erythromycin (as ethylsuccinate) 400 mg tablet, 25

3336N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	15.99	17.20	E-Mycin [AF]

erythromycin (as ethylsuccinate) 400 mg/5 mL powder for oral liquid, 100 mL

2428T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	#19.93	21.50	[a] E-Mycin 400 [AF]
			[B]2.38	#22.31	21.50	[a] E.E.S. Granules [GH]

erythromycin (as ethylsuccinate) 400 mg/5 mL powder for oral liquid, 100 mL

3337P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	#19.93	21.50	[a] E-Mycin 400 [AF]
			[B]2.38	#22.31	21.50	[a] E.E.S. Granules [GH]

▪ ERYTHROMYCIN ETHYLSUCCINATE

Authority required (STREAMLINED)

6160

Severe acne

Clinical criteria:

- The condition must be one in which tetracycline therapy is inappropriate.

erythromycin (as ethylsuccinate) 400 mg tablet, 25

10789W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*20.89	22.10	E-Mycin [AF]

▪ ROXITHROMYCIN

roxithromycin 50 mg dispersible tablet, 10

5259T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	16.72	17.93	Rulide D [SW]

roxithromycin 50 mg dispersible tablet, 10

8129W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	16.72	17.93	Rulide D [SW]

roxithromycin 150 mg tablet, 10

1760P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.57	14.78	[a] APO-Roxithromycin [TX] [a] Chem mart Roxithromycin [CH] [a] Roximycin [AF] [a] Roxithromycin-GA [ED] [a] Roxithromycin Sandoz [SZ]	[a] Biaxsig [AV] [a] Roxar 150 [RW] [a] Roxithromycin AN [EA] [a] Roxithromycin GH [GQ] [a] Terry White Chemists Roxithromycin [TW]
			[B]1.62	15.19	14.78	[a] Rulide [SW]	

roxithromycin 150 mg tablet, 10

5260W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.57	14.78	[a] APO-Roxithromycin [TX] [a] Chem mart Roxithromycin [CH] [a] Roximycin [AF] [a] Roxithromycin-GA [ED] [a] Roxithromycin Sandoz [SZ]	[a] Biaxsig [AV] [a] Roxar 150 [RW] [a] Roxithromycin AN [EA] [a] Roxithromycin GH [GQ] [a] Terry White Chemists Roxithromycin [TW]
			[B]1.62	15.19	14.78	[a] Rulide [SW]	

roxithromycin 300 mg tablet, 5

5261X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.57	14.78	[a] APO-Roxithromycin [TX] [a] Chem mart Roxithromycin [CH] [a] Roximycin [AF] [a] Roxithromycin-GA [ED] [a] Roxithromycin Sandoz [SZ]	[a] Biaxsig [AV] [a] Roxar 300 [RW] [a] Roxithromycin AN [EA] [a] Roxithromycin GH [GQ] [a] Terry White Chemists Roxithromycin [TW]
			[B]1.62	15.19	14.78	[a] Rulide [SW]	

roxithromycin 300 mg tablet, 5

8016X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.57	14.78	[a] APO-Roxithromycin [TX] [a] Chem mart Roxithromycin [CH] [a] Roximycin [AF] [a] Roxithromycin-GA [ED] [a] Roxithromycin Sandoz [SZ]	[a] Biaxsig [AV] [a] Roxar 300 [RW] [a] Roxithromycin AN [EA] [a] Roxithromycin GH [GQ] [a] Terry White Chemists Roxithromycin [TW]
			[B]1.62	15.19	14.78	[a] Rulide [SW]	

Lincosamides

▪ CLINDAMYCIN

Restricted benefit

Gram-positive coccal infections

Clinical criteria:

- The condition must not be able to be safely and effectively treated with a penicillin.

clindamycin 150 mg capsule, 24

5057E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	17.96	19.17	[a] APO-Clindamycin [TX] [a] Chem mart Clindamycin [CH] [a] Clindamycin BNM [BZ] [a] Clindamyk [AF]	[a] Calindamin [RW] [a] Cleocin [FZ] [a] Clindamycin-Link [LI] [a] Terry White Chemists Clindamycin [TW]
			[B]8.60	26.56	19.17	[a] Dalacin C [PF]	

▪ CLINDAMYCIN

Restricted benefit

Gram-positive coccal infections

Clinical criteria:

- The condition must not be able to be safely and effectively treated with a penicillin.

clindamycin 150 mg capsule, 24

3138E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	2	1	..	*24.83	26.04	[a] APO-Clindamycin [TX] [a] Chem mart Clindamycin [CH] [a] Clindamycin BNM [BZ] [a] Clindamyk [AF]	[a] Calindamin [RW] [a] Cleocin [FZ] [a] Clindamycin-Link [LI] [a] Terry White Chemists Clindamycin [TW]
			[B]17.20	*42.03	26.04	[a] Dalacin C [PF]	

▪ LINCOMYCIN

lincomycin 600 mg/2 mL injection, 5 x 2 mL vials

2530E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	1	..	..	142.86	39.50	Lincocin [PF]

lincomycin 600 mg/2 mL injection, 5 x 2 mL vials

5144R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	142.86	39.50	Lincocin [PF]

AMINOGLYCOSIDE ANTIBACTERIALS

Other aminoglycosides

▪ GENTAMICIN

gentamicin 80 mg/2 mL injection, 10 x 2 mL ampoules

2824P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	22.61	23.82	Pfizer Australia Pty Ltd [PF]

▪ TOBRAMYCIN

Restricted benefit

Pseudomonas aeruginosa infection

Clinical criteria:

- Patient must have cystic fibrosis, **AND**
- The treatment must be systemic.

tobramycin 500 mg/5 mL injection, 10 x 5 mL vials

9480Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	279.78	39.50	Tobra-Day [PL]

▪ TOBRAMYCIN

Restricted benefit

Infection where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

tobramycin Injection 80 mg (base) in 2 mL (without preservative), 5

8872Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	1	..	*48.31	39.50	Pfizer Australia Pty Ltd [PF]

tobramycin 80 mg/2 mL injection, 5 x 2 mL vials

1356J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	1	..	*48.31	39.50	[a] Hospira Pty Limited [PF]	[a] Tobramycin Mylan [AF]

▪ TOBRAMYCIN

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4456

Proven Pseudomonas aeruginosa infection

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have cystic fibrosis, **AND**
- Patient must have been assessed for bronchial hyperresponsiveness as per the TGA-approved Product Information, with a negative test result, **AND**
- Patient must be participating in a four week trial of tobramycin inhalation powder and will be assessed for ability to tolerate the dry powder formulation in order to qualify for continued PBS-subsidised therapy. The trial commencement date must be documented in the patient's medical records.

Population criteria:

- Patient must be 6 years of age or older.

tobramycin 28 mg powder for inhalation, 224 capsules

10066T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	2432.37	39.50	TOBI podhaler [NV]

▪ TOBRAMYCIN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4513

Proven Pseudomonas aeruginosa infection

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have cystic fibrosis, **AND**
- Patient must have previously been issued with an authority prescription for tobramycin inhalation capsules, **AND**
- Patient must have demonstrated ability to tolerate the dry powder formulation following the initial 4-week treatment period, as agreed by the patient, the patient's family (in the case of paediatric patients) and the treating physician(s).

Population criteria:

- Patient must be 6 years of age or older.

tobramycin 28 mg powder for inhalation, 224 capsules

10074F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	2432.37	39.50	TOBI podhaler [NV]

▪ TOBRAMYCIN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5520

Proven Pseudomonas aeruginosa infection

Clinical criteria:

- Patient must have cystic fibrosis, **AND**
- The treatment must be for management.

tobramycin 300 mg/5 mL inhalation solution, 56 x 5 mL ampoules

5442K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	1048.47	39.50	[a] Tobi [NV]	[a] Tobramycin AN [EA]

QUINOLONE ANTIBACTERIALS

Fluoroquinolones

▪ CIPROFLOXACIN

Authority required

Respiratory tract infection

Clinical criteria:

- The condition must be proven or suspected to be caused by Pseudomonas aeruginosa, **AND**
- Patient must be severely immunocompromised.

Authority required

Bacterial gastroenteritis

Clinical criteria:

- Patient must be severely immunocompromised.

Authority required

Infection

Clinical criteria:

- The condition must be proven to be due to Pseudomonas aeruginosa resistant to all other oral antimicrobials; OR
- The condition must be proven to be due to other gram-negative bacteria resistant to all other oral antimicrobials.

Authority required

Bone or joint infection

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Epididymo-orchitis

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Prostatitis

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Perichondritis of the pinna

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

ciprofloxacin 500 mg tablet, 14

1209P NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	17.35	18.56	[a] APO-Ciprofloxacin [TX]	[a] C-Flox 500 [AL]
					[a] Cifran [RA]	[a] Ciprofloxacin AN [EA]
					[a] Ciprofloxacin-BW [GQ]	[a] Ciprofloxacin Sandoz [SZ]
					[a] Ciprol 500 [RW]	[a] Loxip 500 [DO]
		[B]2.43	19.78	18.56	[a] Ciproxin 500 [BN]	

ciprofloxacin 750 mg tablet, 14

1210Q NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	20.52	21.73	[a] APO-Ciprofloxacin [TX]	[a] C-Flox 750 [AL]
					[a] Cifran [RA]	[a] Ciprofloxacin AN [EA]
					[a] Ciprofloxacin Sandoz [SZ]	[a] Ciprol 750 [RW]
					[a] Loxip 750 [DO]	

▪ CIPROFLOXACIN

Authority required

Respiratory tract infection

Clinical criteria:

- The condition must be proven or suspected to be caused by Pseudomonas aeruginosa, **AND**
- Patient must be severely immunocompromised.

Authority required

Bacterial gastroenteritis

Clinical criteria:

- Patient must be severely immunocompromised.

Authority required

Infection

Clinical criteria:

- The condition must be proven to be due to Pseudomonas aeruginosa resistant to all other oral antimicrobials; OR
- The condition must be proven to be due to other gram-negative bacteria resistant to all other oral antimicrobials.

Authority required

Bone or joint infection

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR

- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Epididymo-orchitis

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Prostatitis

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Perichondritis of the pinna

Clinical criteria:

- The condition must be suspected or proven to be caused by gram-negative bacteria resistant to all other appropriate antimicrobials; OR
- The condition must be suspected or proven to be caused by gram-positive bacteria resistant to all other appropriate antimicrobials.

Authority required

Gonorrhoea

ciprofloxacin 250 mg tablet, 14

1208N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.29	15.50	[a] APO-Ciprofloxacin [TX] [a] Ciprofloxacin Sandoz [SZ]	[a] C-Flox 250 [AL] [a] Ciprol 250 [RW]
			[B]1.74	16.03	15.50	[a] Ciproxin 250 [BN]	

▪ NORFLOXACIN

Authority required

Acute bacterial enterocolitis

Authority required

Complicated urinary tract infection

norfloxacin 400 mg tablet, 14

3010K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	14.67	15.88	[a] GenRx Norfloxacin [GX] [a] Roxin [RW]	[a] Nufloxib [AF]

OTHER ANTIBACTERIALS

Glycopeptide antibacterials

▪ VANCOMYCIN

Restricted benefit

Endocarditis

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be hypersensitive to penicillin.

vancomycin 500 mg injection, 1 vial

3130R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*21.17	22.38	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

vancomycin 1 g injection, 1 vial

2269K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	17.47	18.68	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

▪ VANCOMYCIN

Restricted benefit

Endocarditis

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be hypersensitive to penicillin.

vancomycin 500 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3323X DP	2	..	..	*21.17	22.38	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

vancomycin 1 g injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5083M DP	1	..	..	17.47	18.68	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

▪ VANCOMYCIN

Restricted benefit

Endophthalmitis

Restricted benefit

Infection

Clinical criteria:

- The treatment must be initiated in a hospital, **AND**
- The condition must be one in which vancomycin is an appropriate antibiotic.

vancomycin 500 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3131T	5	..	..	*36.30	37.51	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

vancomycin 1 g injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2270L	3	..	..	*30.22	31.43	[a] Hospira Pty Limited [PF]	[a] Vancomycin Alphapharm [AF]

Steroid antibacterials

▪ FUSIDATE

Restricted benefit

Serious staphylococcal infections

Clinical criteria:

- The treatment must be used in combination with another antibiotic, **AND**
- The condition must be proven to be due to a staphylococcus.

sodium fusidate 250 mg tablet, 36

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2312Q	1	1	..	84.04	39.50	Fucidin [CS]

▪ FUSIDATE

Authority required (STREAMLINED)

6133

Osteomyelitis

Clinical criteria:

- The condition must be methicillin-resistant staphylococcal aureus (MRSA), **AND**
- The treatment must be used in combination with other anti-staphylococcal antibiotics.

sodium fusidate 250 mg tablet, 36

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10782L	2	1	..	*156.99	39.50	Fucidin [CS]

Imidazole derivatives

▪ METRONIDAZOLE

metronidazole 500 mg suppository, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1642K NP	‡1	..	..	25.65	26.86	Flagyl [SW]

metronidazole 500 mg suppository, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5157K DP	‡1	..	..	25.65	26.86	Flagyl [SW]

metronidazole 200 mg/5 mL oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1630T NP	‡1	..	..	21.87	23.08	Flagyl S [SW]

metronidazole 200 mg/5 mL oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3341W DP	‡1	..	..	21.87	23.08	Flagyl S [SW]

metronidazole 200 mg tablet, 21

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1636D NP	1	1	..	12.36	13.57	[a] Metrogyl 200 [AF]	[a] Metronide 200 [AV]
			[B]2.00	14.36	13.57	[a] Flagyl [SW]	

metronidazole 200 mg tablet, 21

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3339R DP	1	..	..	12.36	13.57	[a] Metrogyl 200 [AF]	[a] Metronide 200 [AV]
			[B]2.00	14.36	13.57	[a] Flagyl [SW]	

▪ METRONIDAZOLE

Restricted benefit
Anaerobic infections

metronidazole 400 mg tablet, 21

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1621H NP	1	1	..	14.07	15.28	[a] Metrogyl 400 [AF]	[a] Metronide 400 [AV]
			[B]2.00	16.07	15.28	[a] Flagyl [SW]	

▪ METRONIDAZOLE

Restricted benefit
Anaerobic infections

metronidazole 400 mg tablet, 21

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5155H DP	1	..	..	14.07	15.28	[a] Metrogyl 400 [AF]	[a] Metronide 400 [AV]
			[B]2.00	16.07	15.28	[a] Flagyl [SW]	

▪ TINIDAZOLE

tinidazole 500 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1465D NP	1	..	..	14.89	16.10	[a] Simplotan [FZ]
			[B]6.70	21.59	16.10	[a] Fasigyn [PF]

Nitrofuran derivatives

▪ NITROFURANTOIN

Caution Nitrofurantoin may cause peripheral neuritis and severe pulmonary reactions.

nitrofurantoin 100 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1693D NP MW	1	1	..	32.12	33.33	Macrodantin [PF]

nitrofurantoin 50 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1692C NP MW	1	1	..	26.08	27.29	Macrodantin [PF]

Other antibacterials

▪ METHENAMINE HIPPURATE

methenamine hippurate 1 g tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3124K NP	1	5	..	44.11	39.50	Hiprex [IA]

▪ ANTIMYCOTICS FOR SYSTEMIC USE

ANTIMYCOTICS FOR SYSTEMIC USE

Triazole derivatives

▪ FLUCONAZOLE

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

Restricted benefit
Cryptococcal meningitis
Restricted benefit
Cryptococcal meningitis
Clinical criteria:
- The treatment must be maintenance therapy, **AND**
- Patient must be immunosuppressed.

Restricted benefit
Oropharyngeal candidiasis
Clinical criteria:
- Patient must be immunosuppressed.

Restricted benefit
Oesophageal candidiasis
Clinical criteria:
- Patient must be immunosuppressed.

Restricted benefit
Oropharyngeal candidiasis
Clinical criteria:
- The treatment must be for prophylaxis, **AND**
- Patient must be immunosuppressed.

Restricted benefit
Candida infections
Clinical criteria:
- The condition must be serious or life-threatening.

fluconazole 100 mg/50 mL injection, 50 mL vial

1473M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	7	..	..	*21.08	22.29	Fluconazole Sandoz [SZ]

fluconazole 100 mg capsule, 28

1472L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	31.81	33.02	[a] Diflucan [PF] [a] Fluconazole Sandoz [SZ]	[a] Dizole 100 [AF] [a] Ozole [RA]

fluconazole 200 mg capsule, 28

1475P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	51.46	39.50	[a] APO-Fluconazole [TX] [a] Dizole 200 [AF] [a] Fluzole 200 [RW]	[a] Diflucan [PF] [a] Fluconazole Sandoz [SZ] [a] Ozole [RA]

fluconazole 50 mg capsule, 28

1471K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.73	22.94	[a] Dizole 50 [AF] [a] Ozole [RA]	[a] Fluconazole Sandoz [SZ]
			[B]6.00	27.73	22.94	[a] Diflucan [PF]	

fluconazole 400 mg/200 mL injection, 200 mL bag

1757L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	15.33	16.54	Fluconazole Alphapharm [AF]

▪ FLUCONAZOLE

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

Restricted benefit
Cryptococcal meningitis
Clinical criteria:
- Patient must be unable to take a solid dose form of fluconazole.

Restricted benefit
Cryptococcal meningitis
Clinical criteria:
- The treatment must be maintenance therapy, **AND**
- Patient must be immunosuppressed, **AND**
- Patient must be unable to take a solid dose form of fluconazole.

Restricted benefit
Oropharyngeal candidiasis

Clinical criteria:

- Patient must be immunosuppressed, **AND**
- Patient must be unable to take a solid dose form of fluconazole.

Restricted benefit

Oesophageal candidiasis

Clinical criteria:

- Patient must be immunosuppressed, **AND**
- Patient must be unable to take a solid dose form of fluconazole.

Restricted benefit

Oropharyngeal candidiasis

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be immunosuppressed, **AND**
- Patient must be unable to take a solid dose form of fluconazole.

Restricted benefit

Candida infections

Clinical criteria:

- The condition must be serious or life-threatening, **AND**
- Patient must be unable to take a solid dose form of fluconazole.

fluconazole 50 mg/5 mL powder for oral liquid, 35 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5446P NP	1	..	..	#67.36	39.50	Diflucan [PF]

▪ FLUCONAZOLE

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

Note Pharmaceutical benefits that have the forms fluconazole 200 mg/100 mL injection, 100 mL vial and fluconazole 200 mg/100 mL injection, 100 mL bag are equivalent for the purposes of substitution.

Restricted benefit

Cryptococcal meningitis

Restricted benefit

Cryptococcal meningitis

Clinical criteria:

- The treatment must be maintenance therapy, **AND**
- Patient must be immunosuppressed.

Restricted benefit

Oropharyngeal candidiasis

Clinical criteria:

- Patient must be immunosuppressed.

Restricted benefit

Oesophageal candidiasis

Clinical criteria:

- Patient must be immunosuppressed.

Restricted benefit

Oropharyngeal candidiasis

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be immunosuppressed.

Restricted benefit

Candida infections

Clinical criteria:

- The condition must be serious or life-threatening.

fluconazole 200 mg/100 mL injection, 100 mL bag

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11139G NP	7	..	..	*46.35	39.50	[a] Fluconazole Alphapharm [AF]

fluconazole 200 mg/100 mL injection, 100 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1474N NP	7	..	..	*46.35	39.50	[a] Fluconazole Sandoz [SZ]

▪ ITRACONAZOLE

Note One capsule of itraconazole 50 mg (Lozanoc) is therapeutically equivalent to one 100 mg capsule of conventional itraconazole (Sporanox). The recommended dose of Lozanoc is therefore half the recommended dose for Sporanox. Lozanoc 50 mg capsules and Sporanox 100 mg capsules are not interchangeable.

Note Not for use in superficial mycoses

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

Restricted benefit
Systemic aspergillosis

Restricted benefit
Systemic sporotrichosis

Restricted benefit
Systemic histoplasmosis

Restricted benefit
Disseminated pulmonary histoplasmosis infection
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- Patient must be diagnosed with acquired immunodeficiency syndrome (AIDS).

Restricted benefit
Chronic pulmonary histoplasmosis infection
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- Patient must be diagnosed with acquired immunodeficiency syndrome (AIDS).

Restricted benefit
Oropharyngeal candidiasis
Clinical criteria:
- Patient must be immunosuppressed.

Restricted benefit
Oesophageal candidiasis
Clinical criteria:
- Patient must be immunosuppressed.

itraconazole 100 mg capsule, 60

8196J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	128.66	39.50	[a] APO-Itraconazole [TX] [a] ITRANOX [RW]	[a] Itracap [AF] [a] Sporanox [JC]

itraconazole 50 mg capsule, 60

10732W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	128.66	39.50	Lozanoc [YN]

▪ POSACONAZOLE

Note Application for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

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

Authority required
Invasive aspergillosis
Clinical criteria:
- Patient must be unable to tolerate alternative therapy; OR
- Patient must have disease refractory to alternative therapy.

Authority required
Prophylaxis of invasive fungal infections including both yeasts and moulds
Clinical criteria:
- Patient must be considered at high risk of developing an invasive fungal infection due to anticipated neutropenia (an absolute neutrophil count less than 500 cells per cubic millimetre), for at least 10 days whilst receiving chemotherapy for acute myeloid leukaemia or myelodysplastic syndrome; OR
- Patient must be considered at high risk of developing an invasive fungal infection due to having acute graft versus host disease (GVHD) grade II, III or IV, or extensive chronic GVHD, and receiving intensive immunosuppressive therapy after allogeneic haematopoietic stem cell transplant.

Treatment of neutropenia should continue until recovery of the neutrophil count to at least 500 cells per cubic millimetre.

Patients who have had a previous invasive fungal infection should have secondary prophylaxis during subsequent episodes of neutropenia.

No more than 6 months therapy per episode will be PBS-subsidised

Authority required

Fungal infection

Clinical criteria:

- The condition must be fusariosis; OR
- The condition must be zygomycosis; OR
- The condition must be coccidioidomycosis; OR
- The condition must be chromoblastomycosis; OR
- The condition must be mycetoma, **AND**
- Patient must be unable to tolerate alternative therapy; OR
- Patient must have disease refractory to alternative therapy.

posaconazole 100 mg modified release tablet, 24

10460M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	834.65	39.50	Noxafil [MK]

▪ POSACONAZOLE

Note Application for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

Note Shared Care Model:

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

Authority required

Invasive aspergillosis

Clinical criteria:

- Patient must be unable to tolerate alternative therapy; OR
- Patient must have disease refractory to alternative therapy.

Authority required

Fungal infection

Clinical criteria:

- The condition must be fusariosis; OR
- The condition must be zygomycosis; OR
- The condition must be coccidioidomycosis; OR
- The condition must be chromoblastomycosis; OR
- The condition must be mycetoma, **AND**
- Patient must be unable to tolerate alternative therapy; OR
- Patient must have disease refractory to alternative therapy.

Authority required

Prophylaxis of invasive fungal infections including both yeasts and moulds

Clinical criteria:

- Patient must be considered at high risk of developing an invasive fungal infection due to anticipated neutropenia (an absolute neutrophil count less than 500 cells per cubic millimetre), for at least 10 days whilst receiving chemotherapy for acute myeloid leukaemia or myelodysplastic syndrome; OR
- Patient must be considered at high risk of developing an invasive fungal infection due to having acute graft versus host disease (GVHD) grade II, III or IV, or extensive chronic GVHD, and receiving intensive immunosuppressive therapy after allogeneic haematopoietic stem cell transplant.

No more than 6 months therapy per episode will be PBS-subsidised

posaconazole 40 mg/mL oral liquid, 105 mL

9360P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	691.97	39.50	Noxafil [MK]

▪ VORICONAZOLE

Note For patients with graft versus host disease, acute myeloid leukaemia or myelodysplastic syndrome, applications for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

Note For patients undergoing allogeneic haematopoietic stem cell transplant, applications for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 2 months' treatment may be authorised.

Note Shared Care Model:

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

Authority required

Prophylaxis of invasive fungal infections including both yeasts and moulds

Clinical criteria:

- Patient must be considered at high risk of developing an invasive fungal infection due to anticipated neutropenia (an absolute neutrophil count less than 500 cells per cubic millimetre) for at least 10 days whilst receiving chemotherapy for acute myeloid leukaemia or myelodysplastic syndrome; OR
- Patient must be considered at high risk of developing an invasive fungal infection due to having acute graft versus host disease (GVHD) grade II, III or IV, or, extensive chronic GVHD, whilst receiving intensive immunosuppressive therapy after allogeneic haematopoietic stem cell transplant; OR
- Patient must be undergoing allogeneic haematopoietic stem cell transplant using either bone marrow from an unrelated donor or umbilical cord blood (related or unrelated), and, be considered to be at high risk of developing an invasive fungal infection during the neutropenic phase prior to engraftment.

voriconazole 50 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10173K NP	1	..	..	411.53	39.50	[a] Vfend [PF] [a] Voriconazole Sandoz [SZ] [a] Vzole [RW]	[a] Voriconazole APOTEX [TX] [a] Vttack [AF]

voriconazole 200 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10198R NP	1	..	..	1590.34	39.50	[a] Vfend [PF] [a] Voriconazole Sandoz [SZ] [a] Vzole [RW]	[a] Voriconazole APOTEX [TX] [a] Vttack [AF]

voriconazole 40 mg/mL powder for oral liquid, 70 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10168E NP	1	..	..	#496.21	39.50	Vfend [PF]

▪ VORICONAZOLE

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

Authority required
Definite or probable invasive aspergillosis
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- Patient must be immunocompromised.

Authority required
Serious fungal infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The condition must be caused by Scedosporium species; OR
- The condition must caused by Fusarium species.

Authority required
Serious Candida infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The condition must be caused by species not susceptible to fluconazole; OR
- The condition must be resistant to fluconazole; OR
- Patient must be unable to tolerate fluconazole.

Authority required
Serious invasive mycosis infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The treatment must be for invasive mycosis infections other than definite or probable invasive aspergillosis.

voriconazole 50 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9363T NP	1	2	..	411.53	39.50	[a] Vfend [PF] [a] Voriconazole Sandoz [SZ] [a] Vzole [RW]	[a] Voriconazole APOTEX [TX] [a] Vttack [AF]

voriconazole 200 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9364W NP	1	2	..	1590.34	39.50	[a] Vfend [PF] [a] Voriconazole Sandoz [SZ] [a] Vzole [RW]	[a] Voriconazole APOTEX [TX] [a] Vttack [AF]

▪ VORICONAZOLE

Note Application for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

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

Authority required
Definite or probable invasive aspergillosis
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- Patient must be immunocompromised.

Authority required
Serious fungal infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The condition must be caused by Scedosporium species; OR
- The condition must caused by Fusarium species.

Authority required
Serious Candida infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The condition must be caused by species not susceptible to fluconazole; OR
- The condition must be resistant to fluconazole; OR
- Patient must be unable to tolerate fluconazole.

Authority required
Serious invasive mycosis infections
Treatment Phase: Treatment and maintenance therapy
Clinical criteria:
- The treatment must be for invasive mycosis infections other than definite or probable invasive aspergillosis.

voriconazole 40 mg/mL powder for oral liquid, 70 mL

9452L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	#496.21	39.50	Vfend [PF]

▪ ANTIMYCOBACTERIALS

DRUGS FOR TREATMENT OF TUBERCULOSIS

Hydrazides

▪ ISONIAZID

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

isoniazid 100 mg tablet, 100

1554T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	23.53	24.74	Arrow Pharma Pty Ltd [RW]

DRUGS FOR TREATMENT OF LEPRA

Drugs for treatment of lepra

▪ DAPSONE

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

dapsone 25 mg tablet, 100

8801F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	288.57	39.50	Link Medical Products Pty Ltd [LM]

dapsone 100 mg tablet, 100

1272Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	353.02	39.50	Link Medical Products Pty Ltd [LM]

▪ RIFAMPICIN

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

Authority required
Leprosy
Population criteria:
- Patient must be an adult.

rifampicin 300 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1983J NP	1	..	..	133.02	39.50	Rimycin 300 [AF]

rifampicin 150 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1982H NP	1	..	..	281.44	39.50	Rimycin 150 [AF]

▪ RIFAMPICIN

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

Restricted benefit
Meningococcal disease
Clinical criteria:
- The treatment must be for prophylaxis, **AND**
- Patient must be a carrier of the disease; OR
- Patient must be in close contact with people who have the disease.

Restricted benefit
Haemophilus influenzae type B
Clinical criteria:
- The treatment must be for prophylaxis, **AND**
- Patient must be in contact with people who have the disease.

rifampicin 150 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1981G NP	1	..	..	37.82	39.03	Rimycin 150 [AF]

rifampicin 100 mg/5 mL oral liquid, 60 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8025J NP	‡1	..	..	30.85	32.06	Rifadin [SW]

rifampicin 300 mg capsule, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1984K NP	1	..	..	23.28	24.49	Rimycin 300 [AF]

▪ ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

▪ ACICLOVIR

Note Aciclovir 200 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.

Authority required (STREAMLINED)
5942
Recurrent moderate to severe genital herpes
Treatment Phase: Episodic treatment or suppressive therapy
Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

aciclovir 200 mg tablet, 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1007B NP	1	5	..	35.63	36.84	[a] Aciclovir 200 [CR] [a] Aciclovir GH [GQ] [a] Acyclo-V 200 [AF] [a] Lovir [EA]	[a] Aciclovir AN [ED] [a] Aciclovir Sandoz [HX] [a] GenRx Aciclovir [GX] [a] Ozvir [RA]

[B]0.91	36.54	36.84	[a] Zovirax 200 mg [GK]	

▪ ACICLOVIR

Note This drug is only effective if commenced within 72 hours of onset of rash.
Note Aciclovir 800 mg is not PBS-subsidised for herpes simplex or chickenpox.
Note No applications for repeats will be authorised.

Authority required (STREAMLINED)
5967
Herpes zoster
Clinical criteria:
- The treatment must be administered within 72 hours of the onset of the rash.

Authority required (STREAMLINED)
5959
Herpes zoster ophthalmicus

aciclovir 800 mg tablet, 35

1052J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	40.79	39.50	[a] Aciclovir 800 [CR] [a] GenRx Aciclovir [GX]	[a] Aciclovir Sandoz [HX]

▪ ACICLOVIR

Note Aciclovir 200 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note For item codes 1003T and 1555W, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.

Authority required (STREAMLINED)
5936
Initial moderate to severe genital herpes
Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

aciclovir 200 mg tablet, 50

1555W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	24.72	25.93	[a] GenRx Aciclovir [GX]

aciclovir 200 mg tablet, 25

1003T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	..	..	*24.73	25.94	[a] Aciclovir Sandoz [HX]

▪ FAMCICLOVIR

Note Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Authority required (STREAMLINED)
5971
Recurrent moderate to severe genital herpes
Treatment Phase: Suppressive therapy
Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

famciclovir 250 mg tablet, 56

8217L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	71.94	39.50	[a] APO-Famciclovir [TX] [a] Ezovir [AF] [a] Famciclovir FBM [FO] [a] Famciclovir generichealth 250 [GQ] [a] Famciclovir SCP 250 [CR] [a] Famvir [HX]	[a] Auro-Famciclovir 250 [DO] [a] Famciclovir AN [EA] [a] Famciclovir-GA [ED] [a] Famciclovir Sandoz [SZ] [a] Famlo [RA] [a] Favic 250 [RW]

▪ FAMCICLOVIR

Note Famciclovir 125 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.
Note Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Authority required (STREAMLINED)
5937
Recurrent moderate to severe genital herpes
Treatment Phase: Episodic treatment

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

famciclovir 125 mg tablet, 40

8092X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	32.82	34.03	[a] APO-Famciclovir [TX] [a] Ezovir [AF] [a] Famciclovir-GA [ED] [a] Favic 125 [RW]	[a] Auro-Famciclovir 125 [DO] [a] Famciclovir AN [EA] [a] Famvir [HX]

famciclovir 250 mg tablet, 20

2274Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	32.82	34.03	[a] APO-Famciclovir [TX] [a] Famciclovir AN [EA] [a] Famciclovir Sandoz [SZ] [a] Favic 250 [RW]	[a] Ezovir [AF] [a] Famciclovir-GA [ED] [a] Famvir [HX]

▪ FAMCICLOVIR

Note This drug is only effective if commenced within 72 hours of onset of rash.

Note Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Note No applications for repeats will be authorised.

Authority required (STREAMLINED)

5951

Herpes zoster

Clinical criteria:

- The treatment must be administered within 72 hours of the onset of the rash.

famciclovir 250 mg tablet, 21

8002E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	33.91	35.12	[a] APO-Famciclovir [TX] [a] Ezovir [AF] [a] Famciclovir-GA [ED] [a] Famciclovir Sandoz [SZ] [a] Famlo [RA] [a] Favic 250 [RW]	[a] Auro-Famciclovir 250 [DO] [a] Famciclovir AN [EA] [a] Famciclovir generichealth 250 [GQ] [a] Famciclovir SCP 250 [CR] [a] Famvir [HX]

▪ FAMCICLOVIR

Note This drug is only effective if commenced within 72 hours of onset of rash.

Note Famciclovir 500 mg is not PBS-subsidised for chickenpox.

Note Famciclovir 500 mg is not PBS-subsidised for herpes zoster, genital herpes or other herpes simplex infections in immunocompetent patients.

Note No applications for repeats will be authorised.

Authority required (STREAMLINED)

5943

Herpes zoster

Clinical criteria:

- Patient must be immunocompromised, **AND**
- The treatment must be administered within 72 hours of the onset of the rash.

famciclovir 500 mg tablet, 30

8897G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	43.69	39.50	[a] APO-Famciclovir [TX] [a] Famciclovir AN [EA] [a] Famvir [HX]	[a] Auro-Famciclovir 500 [DO] [a] Famciclovir Sandoz [SZ] [a] Favic 500 [RW]

▪ FAMCICLOVIR

Note Famciclovir 500 mg is not PBS-subsidised for chickenpox.

Note Famciclovir 500 mg is not PBS-subsidised for herpes zoster, genital herpes or other herpes simplex infections in immunocompetent patients.

Authority required (STREAMLINED)

5954

Recurrent moderate to severe genital herpes

Treatment Phase: Episodic treatment or suppressive therapy

Clinical criteria:

- Patient must be immunocompromised.

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

Authority required (STREAMLINED)

5947

Recurrent moderate to severe oral or labial herpes

Treatment Phase: Episodic treatment

Clinical criteria:

- Patient must have HIV infection, **AND**
- Patient must have a CD4 cell count of less than 500 million per litre.

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

Authority required (STREAMLINED)

5948

Recurrent moderate to severe oral or labial herpes

Treatment Phase: Suppressive therapy

Clinical criteria:

- Patient must have HIV infection, **AND**
- Patient must have CD4 cell counts of less than 150 million per litre.

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

Authority required (STREAMLINED)

5949

Recurrent moderate to severe oral or labial herpes

Treatment Phase: Suppressive therapy

Clinical criteria:

- Patient must have HIV infection, **AND**
- Patient must present with other opportunistic infections or AIDS defining tumours.

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

famciclovir 500 mg tablet, 56

8896F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	71.95	39.50	[a] APO-Famciclovir [TX] [a] Ezovir [AF] [a] Famciclovir-GA [ED] [a] Famciclovir Sandoz [SZ] [a] Favic 500 [RW]	[a] Auro-Famciclovir 500 [DO] [a] Famciclovir AN [EA] [a] Famciclovir generichealth 500 [GQ] [a] Famvir [HX]

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

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

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10665H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	238.48	39.50	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10937P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	86.35	39.50	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10647J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	161.62	39.50	Ibavyr [IX]

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

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

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10666J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	238.48	39.50	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10928E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	86.35	39.50	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10673R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	161.62	39.50	Ibavyr [IX]

▪ VALACICLOVIR

Note Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Authority required (STREAMLINED)

5940

Recurrent moderate to severe genital herpes

Treatment Phase: Suppressive therapy

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

valaciclovir 500 mg tablet, 30

5480K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.35	26.56	[a] APO-Valaciclovir [TX]	[a] Chem mart Valaciclovir [CH]
						[a] Shilova 500 [DO]	[a] Terry White Chemists Valaciclovir [TW]
						[a] Vaclovir [AF]	[a] Valaciclovir AN [EA]
						[a] Valaciclovir generichealth [GQ]	[a] Valaciclovir RBX [RA]
						[a] Valaciclovir SZ [HX]	[a] Valacor 500 [CR]
						[a] Zelitrex [RF]	
			[B]2.26	27.61	26.56	[a] Valtrex [RW]	

▪ VALACICLOVIR

Note Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Authority required (STREAMLINED)

5961

Recurrent moderate to severe genital herpes

Treatment Phase: Episodic treatment

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

valaciclovir 500 mg tablet, 30

8134D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.35	26.56	[a] APO-Valaciclovir [TX]	[a] Chem mart Valaciclovir [CH]
						[a] Shilova 500 [DO]	[a] Terry White Chemists Valaciclovir [TW]
						[a] Vaclovir [AF]	[a] Valaciclovir AN [EA]
						[a] Valaciclovir generichealth [GQ]	[a] Valaciclovir RBX [RA]
						[a] Valaciclovir Sandoz [SZ]	[a] Valaciclovir SZ [HX]
						[a] Valacor 500 [CR]	[a] Zelitrex [RF]
			[B]2.26	27.61	26.56	[a] Valtrex [RW]	

▪ VALACICLOVIR

Note Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

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

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

Authority required (STREAMLINED)

5960

Initial moderate to severe genital herpes

Microbiological confirmation of diagnosis [viral culture, antigen detection or nucleic acid amplification by polymerase chain reaction (PCR)] is desirable but need not delay treatment.

valaciclovir 500 mg tablet, 10

8133C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*20.59	21.80	[a] APO-Valaciclovir [TX] [a] Valaciclovir AN [EA] [a] Zelitrex [RF]	[a] Vaclovir [AF] [a] Valaciclovir Sandoz [SZ]
			[B]2.26	*22.85	21.80	[a] Valtrex [RW]	

▪ VALACICLOVIR

Note This drug is only effective if commenced within 72 hours of onset of rash.

Note Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

Note No applications for repeats will be authorised.

Authority required (STREAMLINED)

5962

Herpes zoster

Clinical criteria:

- The treatment must be administered within 72 hours of the onset of the rash.

Authority required (STREAMLINED)

5968

Herpes zoster ophthalmicus

valaciclovir 500 mg tablet, 42

8064K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	31.05	32.26	[a] APO-Valaciclovir [TX] [a] Terry White Chemists Valaciclovir [TW] [a] Valaciclovir AN [EA] [a] Valaciclovir RBX [RA] [a] Valacor 500 [CR]	[a] Chem mart Valaciclovir [CH] [a] Vaclovir [AF] [a] Valaciclovir generichealth [GQ] [a] Valaciclovir Sandoz [SZ] [a] Zelitrex [RF]
			[B]2.26	33.31	32.26	[a] Valtrex [RW]	

Other antivirals

▪ DACLATASVIR

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

daclatasvir 30 mg tablet, 28

10645G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	7816.19	39.50	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

10642D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	7816.19	39.50	Daklinza [BQ]

▪ DACLATASVIR

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**

- The treatment must be limited to a maximum duration of 24 weeks.

daclatasvir 30 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10671P NP	1	5	..	7816.19	39.50	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10659B NP	1	5	..	7816.19	39.50	Daklinza [BQ]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 16 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11011M NP	1	3	..	21149.52	39.50	Zepatier [MK]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11021C NP	1	2	..	21149.52	39.50	Zepatier [MK]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10628J NP	1	2	..	22216.19	39.50	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**

- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 8 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10668L NP	1	1	..	22216.19	39.50	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10670N NP	1	5	..	22216.19	39.50	Harvoni [GI]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56], 4 x 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10766P NP	1	2	..	14002.65	39.50	Viekira Pak [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10747P NP	1	5	..	14002.65	39.50	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10771X NP	1	5	..	14002.65	39.50	Viekira Pak-RBV [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10769T NP	1	2	..	14002.65	39.50	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10772Y NP	1	2	..	14002.65	39.50	Viekira Pak-RBV [VE]

▪ SOFOSBUVIR

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10624E NP	1	2	..	19447.27	39.50	Sovaldi [GI]

▪ SOFOSBUVIR

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10657X NP	1	5	..	19447.27	39.50	Sovaldi [GI]

▪ SOFOSBUVIR + VELPATASVIR

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg + velpatasvir 100 mg tablet, 28

11147Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	22216.19	39.50	Epclusa [GI]

VACCINES

BACTERIAL VACCINES

Pneumococcal vaccines

PNEUMOCOCCAL PURIFIED CAPSULAR POLYSACCHARIDES

Restricted benefit

Prophylaxis of pneumococcal infection

Clinical criteria:

- Patient must have undergone a splenectomy.

Population criteria:

- Patient must be aged 2 years or older.

Restricted benefit

Prophylaxis of pneumococcal infection

Clinical criteria:

- Patient must have Hodgkin's disease; OR
- Patient must have a high risk of contracting pneumococcal infections.

pneumococcal purified capsular polysaccharides 25 microgram/0.5 mL injection, 0.5 mL vial

1903E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	48.85	39.50	Pneumovax 23 [CS]

pneumococcal purified capsular polysaccharides 25 microgram/0.5 mL injection, 0.5 mL syringe

10210J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	48.85	39.50	Pneumovax 23 [CS]

Tetanus vaccines

DIPHTHERIA TOXOID + TETANUS TOXOID

Note For immunisation of adults and children aged greater than or equal to 8 years.

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

8783G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	70.61	39.50	ADT Booster [CS]

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

10261C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	136.39	39.50	MassBiologics tetanus and diphtheria toxoids adsorbed [CS]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

Nitrogen mustard analogues

CHLORAMBUCIL

chlorambucil 2 mg tablet, 25

1163F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	2	..	*138.39	39.50	Leukeran [AS]

▪ CYCLOPHOSPHAMIDE

cyclophosphamide 50 mg tablet, 50

10026Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	77.48	39.50	Endoxan [BX]

cyclophosphamide 50 mg tablet, 50

1266P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	31.64	32.85	Cycloblastin [ZX]

▪ MELPHALAN

melphalan 2 mg tablet, 25

2547C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	71.85	39.50	Alkeran [AS]

Alkyl sulfonates

▪ BUSULFAN

busulfan 2 mg tablet, 100

1128J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	88.31	39.50	Myleran [AS]

Nitrosoureas

▪ CARMUSTINE

Note Carmustine is not PBS-subsidised for use in conjunction with PBS-subsidised temozolomide.

Restricted benefit

Glioblastoma multiforme

Clinical criteria:

- The condition must be suspected or confirmed at the time of initial surgery.

carmustine 7.7 mg implant, 8

8898H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	16672.83	39.50	Gliadel [EI]

Other alkylating agents

▪ TEMOZOLOMIDE

temozolomide 180 mg capsule, 5

2438H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	202.99	39.50	[a] APO-Temozolomide [TX] [a] Temodal [MK] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temolide [JU]

temozolomide 250 mg capsule, 5

8381D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	286.79	39.50	[a] APO-Temozolomide [TX] [a] Temizole 250 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 100 mg capsule, 5

8380C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	125.76	39.50	[a] APO-Temozolomide [TX] [a] Temizole 100 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 5 mg capsule, 5

8378Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	20.20	21.41	[a] APO-Temozolomide [TX] [a] Temizole 5 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 20 mg capsule, 5

8379B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	37.85	39.06	[a] APO-Temozolomide [TX] [a] Temizole 20 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 140 mg capsule, 5

9362R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	169.23	39.50	[a] APO-Temozolomide [TX] [a] Temizole 140 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

▪ TEMOZOLOMIDE

Note Temozolomide is not PBS-subsidised for use in conjunction with PBS-subsidised carmustine.

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

Restricted benefit

Glioblastoma multiforme

Treatment criteria:

- Patient must be undergoing concomitant radiotherapy.

temozolomide 180 mg capsule, 5

10062N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*599.41	39.50	[a] APO-Temozolomide [TX] [a] Temodal [MK] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temolide [JU]

temozolomide 100 mg capsule, 5

8821G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*360.85	39.50	[a] APO-Temozolomide [TX] [a] Temizole 100 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 5 mg capsule, 5

8819E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*38.41	39.50	[a] APO-Temozolomide [TX] [a] Temizole 5 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 20 mg capsule, 5

8820F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*91.36	39.50	[a] APO-Temozolomide [TX] [a] Temizole 20 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

temozolomide 140 mg capsule, 5

9361Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*495.82	39.50	[a] APO-Temozolomide [TX] [a] Temizole 140 [QA] [a] Temolide [JU] [a] Temozolomide Amneal [ED]	[a] Orion Temozolomide [ON] [a] Temodal [MK] [a] Temozolomide Alphapharm [AF]

ANTIMETABOLITES

Folic acid analogues

▪ METHOTREXATE

methotrexate 10 mg tablet, 15

2272N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	23.19	24.40	Methoblastin [PF]

methotrexate 5 mg/2 mL injection, 5 x 2 mL vials

2396D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	39.94	39.50	Hospira Pty Limited [PF]

methotrexate 2.5 mg tablet, 30

1622J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	16.92	18.13	Methoblastin [PF]

▪ METHOTREXATE

Restricted benefit

Patients requiring doses greater than 20 mg per week

methotrexate 10 mg tablet, 50

1623K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	51.41	39.50	Methoblastin [PF]

▪ METHOTREXATE

Note For item codes 2395C and 1818Q, pharmaceutical benefits that have the form injection 50 mg in 2 mL are equivalent for the purposes of substitution.

METHOTREXATE Injection 50 mg in 2 mL, 1

1818Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	5	..	*38.50	39.50	[a] Methotrexate Accord [OD]

methotrexate 50 mg/2 mL injection, 5 x 2 mL vials

2395C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	38.51	39.50	[a] Hospira Pty Limited [PF]

Purine analogues

▪ FLUDARABINE

fludarabine phosphate 10 mg tablet, 20

9184J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	930.60	39.50	Fludara [GZ]

▪ MERCAPTOPURINE

mercaptopurine monohydrate 50 mg tablet, 25

1598D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	2	..	*243.07	39.50	Purinethol [AS]

mercaptopurine monohydrate 20 mg/mL oral liquid, 100 mL

10214N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	435.07	39.50	Allmercap [LM]

▪ TIOGUANINE

tioguanine 40 mg tablet, 25

1233X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	219.57	39.50	Lanvis [AS]

Pyrimidine analogues

▪ CAPECITABINE

capecitabine 150 mg tablet, 60

8361C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	27.29	28.50	[a] Capecitabine AN [EA] [a] Capecitabine MYX [OC] [a] Xelocitabine [JU]	[a] Capecitabine-DRLA [RZ] [a] Xelabine [QA]

capecitabine 500 mg tablet, 120

8362D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	111.51	39.50	[a] Capecitabine Alphapharm [AF] [a] Capecitabine Apotex [TX] [a] Capecitabine MYX [OC] [a] Xelabine [QA] [a] Xeloda [RO]	[a] Capecitabine AN [EA] [a] Capecitabine-DRLA [RZ] [a] Capecitabine Sandoz [SZ] [a] Xelocitabine [JU]

PLANT ALKALOIDS AND OTHER NATURAL PRODUCTS

Vinca alkaloids and analogues

▪ VINORELBINE

Authority required

Advanced breast cancer

Clinical criteria:

- Patient must have failed standard prior therapy, which includes an anthracycline.

Authority required

Locally advanced or metastatic non-small cell lung cancer

vinorelbine 20 mg capsule, 1

9009E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	20	2	..	*1570.15	39.50	Navelbine [FB]

vinorelbine 30 mg capsule, 1

9010F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	16	2	..	*1878.83	39.50	Navelbine [FB]

Podophyllotoxin derivatives

▪ ETOPOSIDE

etoposide 50 mg capsule, 20

1396L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	440.03	39.50	Vepesid [BQ]

etoposide 100 mg capsule, 10

1389D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	383.92	39.50	Vepesid [BQ]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

▪ IDARUBICIN

Restricted benefit

Acute myelogenous leukaemia (AML)

idarubicin hydrochloride 10 mg capsule, 1

2448W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*490.51	39.50	Zavedos [PF]

idarubicin hydrochloride 5 mg capsule, 1

2446R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*306.61	39.50	Zavedos [PF]

OTHER ANTINEOPLASTIC AGENTS

Monoclonal antibodies

▪ RITUXIMAB

Authority required (STREAMLINED)

7400

Previously untreated or relapsed/refractory CD20 positive lymphoid cancer

Treatment Phase: Induction or re-induction therapy

Clinical criteria:

- The treatment must be for induction or re-induction for CD20 positive lymphoma; OR
- The treatment must be for induction or re-induction for CD20 positive chronic lymphocytic leukaemia; OR
- The treatment must be for induction or consolidation for CD20 positive acute lymphoblastic leukaemia, **AND**
- The treatment must be in combination with chemotherapy, **AND**

- Patient must not receive more than the number of cycles of treatment recommended by standard guidelines for the partner chemotherapy under this restriction.

An initial dose of rituximab must be administered with rituximab intravenous injection. Subsequent doses may be administered with either intravenous or subcutaneous rituximab.

No more than 8 doses in total as per course of treatment will be allowed for lymphoma or chronic lymphocytic leukaemia.

No more than 12 doses in total as per course of treatment will be allowed for acute lymphoblastic leukaemia for induction course (including consolidation course).

rituximab 1.4 g/11.7 mL injection, 11.7 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10703H	1	6	..	2799.22	39.50	Mabthera SC [RO]

▪ RITUXIMAB

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

Authority required (STREAMLINED)

6011

Relapsed or refractory Stage III or IV CD20 positive follicular B-cell non-Hodgkin's lymphoma

Treatment Phase: Maintenance therapy

Clinical criteria:

- The treatment must be maintenance therapy, **AND**
- Patient must have demonstrated a partial or complete response to re-induction treatment received immediately prior to this current Authority application, **AND**
- Patient must not receive more than 8 cycles or 2 years duration of treatment, whichever comes first, under this restriction.

rituximab 1.4 g/11.7 mL injection, 11.7 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10709P	1	7	..	2799.22	39.50	Mabthera SC [RO]

▪ RITUXIMAB

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

Authority required (STREAMLINED)

7399

Previously untreated or Relapsed/refractory CD20 positive acute lymphoblastic leukaemia

Treatment Phase: Maintenance therapy

Clinical criteria:

- The treatment must be maintenance therapy, **AND**
- The treatment must be in combination with chemotherapy, **AND**
- Patient must be in complete remission, **AND**
- Patient must not receive more than 6 doses in total under this restriction.

rituximab 1.4 g/11.7 mL injection, 11.7 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10719E	1	5	..	2799.22	39.50	Mabthera SC [RO]

▪ RITUXIMAB

Note A patient may only qualify for PBS-subsidised treatment under this restriction once in a lifetime.

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

Authority required (STREAMLINED)

6161

Stage III or IV CD20 positive follicular B-cell non-Hodgkin's lymphoma

Treatment Phase: Maintenance therapy

Clinical criteria:

- Patient must have demonstrated a partial or complete response to induction treatment with either R-CHOP or R-CVP regimens for previously untreated follicular B-cell Non-Hodgkin's lymphoma, received immediately prior to this current Authority application, **AND**
- Patient must not have received bendamustine induction therapy, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not receive more than 12 doses or 2 years duration of treatment, whichever comes first, under this restriction.

rituximab 1.4 g/11.7 mL injection, 11.7 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10742J	1	11	..	2799.22	39.50	Mabthera SC [RO]

▪ TRASTUZUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Locally advanced HER2 positive breast cancer

Treatment Phase: Continuing treatment (3 weekly regimen)

Clinical criteria:

- Patient must have previously received treatment with PBS-subsidised trastuzumab, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure, **AND**
- Patient must not receive more than 52 weeks of combined PBS-subsidised and non-PBS-subsidised therapy.

Cardiac function must be tested by a suitable method including, for example, ECHO or MUGA, at 3 monthly intervals during treatment.

Where a patient has a break in trastuzumab therapy of more than 1 week but less than 6 weeks from when the last dose was due, authority approval will be granted for a new loading dose.

Authority required

Early HER2 positive breast cancer

Treatment Phase: Continuing treatment (3 weekly regimen)

Clinical criteria:

- Patient must have previously received treatment with PBS-subsidised trastuzumab, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure, **AND**
- Patient must not receive more than 52 weeks of combined PBS-subsidised and non-PBS-subsidised therapy.

Cardiac function must be tested by a suitable method including, for example, ECHO or MUGA, at 3 monthly intervals during treatment.

Where a patient has a break in trastuzumab therapy of more than 1 week but less than 6 weeks from when the last dose was due, authority approval will be granted for a new loading dose.

trastuzumab 600 mg/5 mL injection, 5 mL vial

10682F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	2945.37	39.50	Herceptin SC [RO]

▪ TRASTUZUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Locally advanced HER2 positive breast cancer

Treatment Phase: Initial treatment (3 weekly regimen)

Clinical criteria:

- Patient must commence treatment concurrently with neoadjuvant chemotherapy, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure, **AND**
- Patient must not receive more than 52 weeks of combined PBS-subsidised and non-PBS-subsidised therapy.

HER2 positivity must be demonstrated by in situ hybridisation (ISH).

Authority applications for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Early Breast Cancer - PBS Supporting Information Form which includes:

(i) a copy of the pathology report from an Approved Pathology Authority confirming the presence of HER2 gene amplification by in situ hybridisation (ISH); and

(ii) a copy of the signed patient acknowledgement form.

Cardiac function must be tested by a suitable method including, for example, ECHO or MUGA, prior to seeking the initial authority approval and then at 3 monthly intervals during treatment.

Authority required

Early HER2 positive breast cancer

Treatment Phase: Initial treatment (3 weekly regimen)

Clinical criteria:

- Patient must commence treatment concurrently with adjuvant chemotherapy, **AND**
- Patient must have undergone surgery, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure, **AND**
- Patient must not receive more than 52 weeks of combined PBS-subsidised and non-PBS-subsidised therapy.

HER2 positivity must be demonstrated by in situ hybridisation (ISH).

Authority applications for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Early Breast Cancer - PBS Supporting Information Form which includes:

(i) a copy of the pathology report from an Approved Pathology Authority confirming the presence of HER2 gene amplification by in situ hybridisation (ISH); and

(ii) a copy of the signed patient acknowledgement form.

Cardiac function must be tested by a suitable method including, for example, ECHO or MUGA, prior to seeking the initial authority approval and then at 3 monthly intervals during treatment.

trastuzumab 600 mg/5 mL injection, 5 mL vial

10721G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	2945.37	39.50	Herceptin SC [RO]

▪ TRASTUZUMAB

Note No applications for increased maximum quantities will be authorised.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Metastatic (Stage IV) HER2 positive breast cancer

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have evidence of human epidermal growth factor receptor 2 (HER2) gene amplification as demonstrated by in situ hybridisation (ISH) either in the primary tumour or a metastatic lesion, **AND**
- The treatment must not be in combination with nab-paclitaxel, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure.

Authority applications for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Late stage metastatic breast cancer Initial PBS authority application form which includes a copy of the pathology report from an Approved Pathology Authority confirming evidence of HER2 gene amplification in the primary tumour or a metastatic lesion by in situ hybridisation (ISH) and tick a box to state the patient has Stage IV disease.

Cardiac function must be tested by echocardiography (ECHO) or multigated acquisition (MUGA), prior to seeking the initial authority approval and then at 3 monthly intervals during treatment.

trastuzumab 600 mg/5 mL injection, 5 mL vial

10798H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	2945.37	39.50	Herceptin SC [RO]

▪ TRASTUZUMAB

Note No applications for increased maximum quantities will be authorised.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Special Pricing Arrangements apply.

Authority required

Metastatic (Stage IV) HER2 positive breast cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**

- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure.

Where a patient has a break in trastuzumab therapy of more than 1 week from when the last dose was due, authority approval will be granted for a new loading dose.

Cardiac function must be tested by echocardiography (ECHO) or multigated acquisition (MUGA), at 3 monthly intervals during treatment.

trastuzumab 600 mg/5 mL injection, 5 mL vial

10803N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	2945.37	39.50	Herceptin SC [RO]

▪ TRASTUZUMAB

Note No applications for increased maximum quantities will be authorised.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Special Pricing Arrangements apply.

Authority required

HER2 positive breast cancer

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition before 1 July 2015, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure.

Cardiac function must be tested by echocardiography (ECHO) or multigated acquisition (MUGA), at 3 monthly intervals during treatment.

trastuzumab 600 mg/5 mL injection, 5 mL vial

10825R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	2945.37	39.50	Herceptin SC [RO]

Protein kinase inhibitors

▪ ALECTINIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must have a WHO performance status of 2 or less.

Population criteria:

- Patient must have evidence of an anaplastic lymphoma kinase (ALK) gene rearrangement in tumour material, defined as 15% (or greater) positive cells by fluorescence in situ hybridisation (FISH) testing.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 January 2018, **AND**
- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must not have progressive disease while receiving treatment with this drug for this condition.

Population criteria:

- Patient must have evidence of an anaplastic lymphoma kinase (ALK) gene rearrangement in tumour material, defined as 15% (or greater) positive cells by fluorescence in situ hybridisation (FISH) testing.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

alectinib 150 mg capsule, 4 x 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11226W	1	1	..	6802.60	39.50	Alecensa [RO]

▪ AXITINIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Prescribers may request an increased maximum quantity sufficient to provide up to one month's supply for patients who require dose adjustment.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

axitinib 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10556N	2	5	..	*5189.53	39.50	Inlyta [PF]

axitinib 1 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10539Q	2	5	..	*1120.45	39.50	Inlyta [PF]

▪ AXITINIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have progressive disease according to the Response Evaluation Criteria In Solid Tumours (RECIST) following first-line treatment with a tyrosine kinase inhibitor, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have developed intolerance to a tyrosine kinase inhibitor of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised treatment with this drug.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

Prescribers may request an increased maximum quantity sufficient to provide up to one month's supply for patients who require dose adjustment.

axitinib 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10540R	2	2	..	*5189.53	39.50	Inlyta [PF]

axitinib 1 mg tablet, 28

10572K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	2	..	*1120.45	39.50	Inlyta [PF]

▪ CERITINIB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)
Treatment Phase: Initial treatment
Clinical criteria:
- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must have a WHO performance status of 2 or less.

Population criteria:
- Patient must have evidence of an anaplastic lymphoma kinase (ALK) gene rearrangement in tumour material, defined as 15% (or greater) positive cells by fluorescence in situ hybridisation (FISH) testing.

Authority required
Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)
Treatment Phase: Continuing treatment
Clinical criteria:
- The treatment must be as monotherapy, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

Authority required
Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)
Treatment Phase: Grandfathering treatment
Clinical criteria:
- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 February 2017, **AND**
- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must not have progressive disease.

Population criteria:
- Patient must have evidence of an anaplastic lymphoma kinase (ALK) gene rearrangement in tumour material, defined as 15% (or greater) positive cells by fluorescence in situ hybridisation (FISH) testing.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

ceritinib 150 mg capsule, 3 x 50

11056X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	7277.82	39.50	Zykadia [NV]

▪ COBIMETINIB

Note No increase in the maximum number of repeats may be authorised.
Note No increase in the maximum quantity or number of units may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)
6839
Unresectable Stage III or Stage IV malignant melanoma
Treatment Phase: Initial treatment
Clinical criteria:
- Patient must be receiving PBS subsidised vemurafenib concomitantly for this condition, **AND**
- Patient must not have progressive disease when treated with a BRAF inhibitor.

cobimetinib 20 mg tablet, 63

11074W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	8187.55	39.50	Cotellic [RO]

▪ COBIMETINIB

Note A patient who has had progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.
Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6803

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must be receiving PBS-subsidised vemurafenib concomitantly for this condition, **AND**
- Patient must have stable or responding disease.

cobimetinib 20 mg tablet, 63

11075X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	8187.55	39.50	Cotellic [RO]

▪ CRIZOTINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must have a WHO performance status of 2 or less.

Population criteria:

- Patient must have evidence of an anaplastic lymphoma kinase (ALK) gene rearrangement in tumour material, defined as 15% (or greater) positive cells by fluorescence in situ hybridisation (FISH) testing.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed ALK-Positive Non-Small-Cell Lung Cancer Authority Application - Supporting Information Form, which includes details of ALK gene rearrangement in tumour material by FISH testing.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

crizotinib 250 mg capsule, 60

10322G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	7277.82	39.50	Xalkori [PF]

crizotinib 200 mg capsule, 60

10323H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	7277.82	39.50	Xalkori [PF]

▪ DABRAFENIB

Note A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6044

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be positive for a BRAF V600 mutation, **AND**
- The condition must not have been treated previously with PBS subsidised therapy; OR
- Patient must have developed intolerance to another BRAF inhibitor of a severity necessitating permanent treatment withdrawal, **AND**
- Patient must have a WHO performance status of 2 or less.

dabrafenib 75 mg capsule, 120

2846T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	8761.69	39.50	Tafinlar [NV]

dabrafenib 50 mg capsule, 120

2963Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	5890.97	39.50	Tafinlar [NV]

▪ DABRAFENIB

Note A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

Note A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6013

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must have stable or responding disease.

dabrafenib 75 mg capsule, 120

10003L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	8761.69	39.50	Tafinlar [NV]

dabrafenib 50 mg capsule, 120

2954L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5890.97	39.50	Tafinlar [NV]

▪ DASATINIB

Note The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesilate, dasatinib or nilotinib.
Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.
1. Initial First-line treatment From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesilate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure to respond
2. Continuing First-line treatment
Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.
First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.
Second and subsequent authority applications for continuing therapy may be made by telephoning the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason of intolerance. Where there is failure to respond, switching may only occur through application for prescription of second-line agents.Where a patient has previously received PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.
3. Authority approval requirements.Response criteria to initial first-line treatment with imatinib mesilate, dasatinib or nilotinib:For the purposes of assessing response to PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using

the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesilate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

4. Definitions of response

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

5. Definitions of loss of response

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be a primary diagnosis, **AND**
- The condition must be in the chronic phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase, **AND**
- The treatment must be for first line therapy for this condition, **AND**
- Patient must not have previously experienced a failure to respond to the PBS-subsidised first line treatment with this drug for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- The treatment must not exceed a total maximum of 18 months of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.

Patients should be commenced on a dose of dasatinib of 100 mg (base) daily. Continuing therapy is dependent on patients demonstrating a response to dasatinib therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form; and

(3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and

(4) a signed patient acknowledgement form

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: First continuing treatment

Clinical criteria:

- The condition must be in the chronic phase, **AND**
- Patient must have received initial PBS-subsidised first line treatment with this drug for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- Patient must have demonstrated a major cytogenic response; OR
- Patient must have demonstrated a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

First continuing applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) demonstration of continued response to treatment as evidenced by either:(a) a major cytogenetic response [see Note explaining requirements]; or(b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements].Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Subsequent continuing treatment

Clinical criteria:

- The condition must be in the chronic phase, **AND**
- Patient must have received the First continuing PBS-subsidised treatment with this drug as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- Patient must have maintained a major cytogenic response; OR
- Patient must have maintained a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Subsequent authority applications for continuing therapy with this drug may be made by telephoning the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

dasatinib 50 mg tablet, 60

1381Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	4764.09	39.50	Sprycel [BQ]

dasatinib 20 mg tablet, 60

1354G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2951.16	39.50	Sprycel [BQ]

dasatinib 70 mg tablet, 60

1415L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5862.66	39.50	Sprycel [BQ]

dasatinib 100 mg tablet, 30

1416M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	4764.09	39.50	Sprycel [BQ]

▪ DASATINIB

Note The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for all phases of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to dasatinib or nilotinib. Imatinib mesilate is not approved for use in second or third line treatment.Patients are eligible for PBS-subsidised treatment with only one of dasatinib or nilotinib at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between these agents if they have not failed prior PBS-subsidised treatment with that agent.Nilotinib is not approved for patients in blast crisis.1. Initial second line treatmentFrom 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib within the initial 18 month treatment period as second-line therapy, as long as only one agent is approved at a time and providing the patient did not fail that drug as first-line therapy.During the initial 18 month treatment period, switching between approved second-line agents may only occur for reasons of intolerance, not failure of response.2. Initial third line treatmentThird-line treatment with a TKI can only be approved when imatinib is used for first-line treatment. Patients will only be approved for PBS-subsidised treatment with one third-line agent.From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib providing the patient did not fail that drug as first or second line therapy and for nilotinib the patient is not in blast crisis.3. Continuing treatment for second and third line treatmentAll continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.During second line continuing treatment beyond the initial 18 month treatment period, switching between approved second line TKI agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of a third line agent.4. Authority approval requirements.Response criteria to initial treatment with dasatinib or nilotinib:For the purposes of assessing response to PBS-subsidised treatment with dasatinib or nilotinib, either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).5. Definitions of response.A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.6. Definitions of loss of response.Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have failed PBS-subsidised first line treatment with this drug for this condition, **AND**
- Patient must have failed an adequate trial of PBS-subsidised first line treatment with imatinib for this condition; OR
- Patient must have failed an adequate trial of PBS-subsidised first line treatment with nilotinib for this condition; OR
- Patient must have experienced intolerance, not a failure of response, to PBS-subsidised second line treatment with nilotinib for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Failure of an adequate trial of imatinib or nilotinib is defined as:(i) Lack of response to initial imatinib or nilotinib therapy, defined as either:- failure to achieve a haematological response after a minimum of 3 months therapy with imatinib or nilotinib for patients initially treated in chronic phase; or- failure to achieve any cytogenetic response after a minimum of 6 months therapy with imatinib or nilotinib for patients initially treated in chronic phase as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or- failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with imatinib or nilotinib; OR(ii) Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing imatinib or nilotinib therapy; OR(iii) Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing imatinib or nilotinib therapy; OR(iv) Development of accelerated phase or blast crisis in a patient previously prescribed imatinib or nilotinib for any phase of chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or(2) Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or(3) Peripheral basophils greater than or equal to 20%; or(4) Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or(5) Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome); ORBlast crisis is defined as either:(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or(2) Extramedullary involvement other than spleen and liver; OR(v) Disease progression (defined as a greater than or equal to 50% increase in peripheral white blood cell count, blast count, basophils or platelets) during first-line imatinib or nilotinib therapy in patients with accelerated phase or blast crisis chronic myeloid leukaemia.Patients should be commenced on a dose of dasatinib of at least 100 mg (base) daily. Continuing therapy is dependent on patients demonstrating a major cytogenetic response to dasatinib therapy or a peripheral blood BCR-ABL level of less than 1% within 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:(a) a completed authority prescription form; and(b) a completed Chronic Myeloid Leukaemia - Second and Third Line - Supporting Information Form; and(c) a signed patient acknowledgement; and(d) a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale. (The date of the relevant pathology report needs to be provided); and(e) where there has been a loss of response to imatinib or nilotinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have received initial PBS- subsidised second line treatment with this drug for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to PBS-subsidised second line treatment with nilotinib for this condition, **AND**
- Patient must have demonstrated a major cytogenetic response in the preceding 18 months and thereafter at 12 monthly intervals; OR
- Patient must have achieved a peripheral blood level of BCR-ABL of less than 1% in the preceding 18 months and thereafter at 12 monthly intervals, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed Chronic Myeloid Leukaemia - Second and Third Line - Application Form for continuing treatment; and (3) demonstration of continued response to treatment as evidenced by either: (a) major cytogenetic response [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report need be provided; or (b) a peripheral blood level of BCR-ABL of less than 1% on the international scale on the international scale [see Note explaining definitions of response]. Where this has

been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report need be provided.

dasatinib 50 mg tablet, 60

2482P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	4764.09	39.50	Sprycel [BQ]

dasatinib 20 mg tablet, 60

2478K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2951.16	39.50	Sprycel [BQ]

dasatinib 70 mg tablet, 60

2485T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5862.66	39.50	Sprycel [BQ]

dasatinib 100 mg tablet, 30

9342Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	4764.09	39.50	Sprycel [BQ]

▪ DASATINIB

Note Dasatinib will only be subsidised for patients with acute lymphoblastic leukaemia who are not receiving concomitant PBS-subsidised imatinib mesilate and who are not appropriate for an allogeneic haemopoietic stem cell transplant.

Note No applications for increased repeats will be authorised.

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- Patient must have failed treatment with chemotherapy, **AND**
- Patient must have failed treatment with imatinib, **AND**
- Patient must have failed an allogeneic haemopoeitic stem cell transplantation if applicable, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Failure of treatment is defined as either:

(i) Failure to achieve a complete morphological and cytogenetic remission after a minimum of 2 months treatment with intensive chemotherapy and imatinib;

(ii) Morphological or cytogenetic relapse of leukaemia after achieving a complete remission induced by chemotherapy and imatinib;

(iii) Morphological or cytogenetic relapse or persistence of leukaemia after allogeneic haemopoietic stem cell transplantation.

Patients must have active leukaemia, as defined by presence on current pathology assessments of either morphological infiltration of the bone marrow (greater than 5% lymphoblasts) or cerebrospinal fluid or other sites; OR the presence of cells expressing the Philadelphia chromosome on cytogenetic or FISH analysis in the bone marrow of patients in morphological remission.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Acute Lymphoblastic Leukaemia Dasatinib PBS Authority Application - Supporting Information Form; and

(c) a signed patient acknowledgement; and

(d) a pathology report demonstrating that the patient has active acute lymphoblastic leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or morphological evidence of acute lymphoblastic leukaemia plus qualitative RT-PCR evidence of BCR-ABL transcript. The date of the relevant pathology report(s) need(s) to be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Initial Treatment

Clinical criteria:

- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- Patient must have been treated for this condition prior to 1 December 2007, **AND**
- Patient must have failed treatment with chemotherapy, **AND**

- Patient must have failed an allogeneic haemopoeitic stem cell transplantation if applicable, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients must have active leukaemia, as defined by presence on current pathology assessments of either morphological infiltration of the bone marrow (greater than 5% lymphoblasts) or cerebrospinal fluid or other sites; OR the presence of cells expressing the Philadelphia chromosome on cytogenetic or FISH analysis in the bone marrow of patients in morphological remission.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Acute Lymphoblastic Leukaemia Dasatinib PBS Authority Application - Supporting Information Form; and

(c) a signed patient acknowledgement; and

(d) a pathology report demonstrating that the patient has active acute lymphoblastic leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or morphological evidence of acute lymphoblastic leukaemia plus qualitative RT-PCR evidence of BCR-ABL transcript. The date of the relevant pathology report(s) need(s) to be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The condition must not have progressed, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Note Authority applications for continuing treatment may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

dasatinib 50 mg tablet, 60

9126H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	4764.09	39.50	Sprycel [BQ]

dasatinib 20 mg tablet, 60

9125G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	2951.16	39.50	Sprycel [BQ]

dasatinib 70 mg tablet, 60

9127J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	5862.66	39.50	Sprycel [BQ]

dasatinib 100 mg tablet, 30

9343R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	4764.09	39.50	Sprycel [BQ]

▪ ERLOTINIB

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously been issued with an authority prescription for this drug prior to 1 August 2014, **AND**
- Patient must not have progressive disease.

Population criteria:

- Patient must have a wild type epidermal growth factor receptor (EGFR) gene; OR
- Patient must have an epidermal growth factor receptor (EGFR) gene of unknown type.

erlotinib 100 mg tablet, 30

10019H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1173.53	39.50	Tarceva [RO]

erlotinib 150 mg tablet, 30

10025P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1433.50	39.50	Tarceva [RO]

erlotinib 25 mg tablet, 30

10028T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	329.57	39.50	Tarceva [RO]

▪ ERLOTINIB

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); OR
- Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal, **AND**
- Patient must have a WHO performance status of 2 or less.

Population criteria:

- Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have progressive disease.

Population criteria:

- Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

erlotinib 100 mg tablet, 30

10020J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1173.53	39.50	Tarceva [RO]

erlotinib 150 mg tablet, 30

10014C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1433.50	39.50	Tarceva [RO]

erlotinib 25 mg tablet, 30

10022L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	329.57	39.50	Tarceva [RO]

▪ EVEROLIMUS

Note Special Pricing Arrangements apply.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR
- The condition must be visceral tumours associated with TSC, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must not be a candidate for curative surgical resection.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR
- The condition must be visceral tumours associated with TSC, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been treated with PBS-subsidised everolimus for this condition, **AND**

- Patient must have demonstrated a response to prior treatment.

everolimus 2.5 mg tablet, 30

2818H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1404.57	39.50	Afinitor [NV]

▪ EVEROLIMUS

Note Special Pricing Arrangements apply.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR
- The condition must be visceral tumours associated with TSC, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must not be a candidate for curative surgical resection.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR
- The condition must be visceral tumours associated with TSC, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been treated with PBS-subsidised everolimus for this condition, **AND**
- Patient must have demonstrated a response to prior treatment.

Authority required

Metastatic (Stage IV) breast cancer

Clinical criteria:

- The condition must be hormone receptor positive, **AND**
- The condition must be human epidermal growth factor receptor 2 (HER2) negative, **AND**
- The condition must have acquired endocrine resistance as demonstrated by initial response and then recurrence or progression of disease after treatment with letrozole or anastrozole, **AND**
- The treatment must be in combination with exemestane.

Population criteria:

- Patient must not be pre-menopausal.

Note Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

everolimus 10 mg tablet, 30

2985D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5279.52	39.50	Afinitor [NV]

everolimus 5 mg tablet, 30

2819J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	2714.52	39.50	Afinitor [NV]

▪ EVEROLIMUS

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

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have disease progression, **AND**
- The treatment must be as monotherapy.

Patients who have progressive disease with this drug are no longer eligible for PBS-subsidised treatment with this drug.

everolimus 10 mg tablet, 30

10135K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5279.52	39.50	Afinitor [NV]

everolimus 5 mg tablet, 30

10131F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2714.52	39.50	Afinitor [NV]

▪ EVEROLIMUS

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

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have progressive disease according to the Response Evaluation Criteria In Solid Tumours (RECIST) following first-line treatment with a tyrosine kinase inhibitor, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have developed intolerance to a tyrosine kinase inhibitor of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised everolimus.

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be symptomatic (despite somatostatin analogues); OR
- Patient must have disease progression, **AND**
- The treatment must be as monotherapy.

Disease progression must be documented in the patient's medical records.

Patients who have developed progressive disease on sunitinib are not eligible to receive PBS-subsidised everolimus.

Patients who have developed intolerance to sunitinib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised everolimus.

everolimus 10 mg tablet, 30

10132G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	5279.52	39.50	Afinitor [NV]

everolimus 5 mg tablet, 30

10133H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	2714.52	39.50	Afinitor [NV]

▪ GEFITINIB

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**
- Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); OR

- Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal, **AND**
- Patient must have a WHO performance status of 2 or less.

Population criteria:

- Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have progressive disease.

gefitinib 250 mg tablet, 30

8769M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1433.50	39.50	Iressa [AP]

▪ IBRUTINIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic lymphocytic leukaemia (CLL) or small lymphocytic lymphoma (SLL)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- The condition must have relapsed or be refractory to at least one prior therapy, **AND**
- Patient must have a WHO performance status of 0 or 1, **AND**
- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must be considered unsuitable for treatment or retreatment with a purine analogue.

A patient is considered unsuitable for treatment or retreatment with a purine analogue as demonstrated by at least one of the following:

a) Failure to respond (stable disease or disease progression on treatment), or a progression-free interval of less than 3 years from treatment with a purine analogue-based therapy and anti-CD20-containing chemoimmunotherapy regimen after at least two cycles;

b) Age is 70 years or older;

c) Age is 65 years or older and the presence of comorbidities (Cumulative Illness Rating Scale of 6 or greater, or creatinine clearance of less than 70 mL/min) that might place the patient at an unacceptable risk for treatment-related toxicity with purine analogue-based therapy, provided they have received one or more prior treatment including at least two cycles of an alkylating agent-based (or purine analogue-based) anti-CD20 antibody-containing chemoimmunotherapy regimen;

d) History of purine analogue-associated autoimmune anaemia or autoimmune thrombocytopenia;

e) Evidence of one or more 17p chromosomal deletions demonstrated by fluorescence in situ hybridisation (FISH).

Authority required

Chronic lymphocytic leukaemia (CLL) or small lymphocytic lymphoma (SLL)

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

ibrutinib 140 mg capsule, 90

11213E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	8782.81	39.50	Imbruvica [JC]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Authority required

Malignant gastrointestinal stromal tumour

Treatment Phase: Initial Treatment

Clinical criteria:

- The condition must be metastatic; OR
- The condition must be unresectable, **AND**
- The condition must be histologically confirmed by the detection of CD117 on immunohistochemical staining, **AND**
- The treatment must be commenced at a dose not exceeding 400 mg per day, **AND**
- The treatment must not exceed 3 months under this restriction.

Authority prescriptions for a higher dose will not be approved during this initial 3 month treatment period.

Patients with metastatic/unresectable disease who achieve a response to treatment at an imatinib dose of 400 mg per day should be continued at this dose and assessed for response at regular intervals. Patients who fail to achieve a response to 400 mg per day may have their dose increased to 600 mg per day. Authority applications for doses higher than 600 mg per day will not be approved.

A response to treatment is defined as a decrease from baseline in the sum of the products of the perpendicular diameters of all measurable lesions of 50% or greater. (Response definition based on the Southwest Oncology Group standard criteria, see Demetri et al. N Engl J Med 2002; 347: 472-80.)

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Imatinib Mesilate PBS Authority Application for Use in the Treatment of Metastatic or Unresectable Gastrointestinal Stromal Tumour - Supporting Information Form which includes the following:

(i) a copy of a pathology report from an Approved Pathology Authority supporting the diagnosis of a gastrointestinal stromal tumour and confirming the presence of CD117 on immunohistochemical staining; and

(ii) a copy of the most recent (within 2 months of the application) computed tomography (CT) scan, magnetic resonance imaging (MRI) or ultrasound assessment of the tumour(s), including whether or not there is evidence of metastatic disease; and

(iii) where the application for authority to prescribe is being sought on the basis of an unresectable tumour, written evidence in support of that claim must be provided

Authority required

Malignant gastrointestinal stromal tumour

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be metastatic; OR
- The condition must be unresectable, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be given at a dose not exceeding 600 mg per day.

Patients who have failed to respond or are intolerant to imatinib are no longer eligible to receive PBS-subsidised imatinib

Patients with metastatic/unresectable disease who achieve a response to treatment at an imatinib dose of 400 mg per day should be continued at this dose and assessed for response at regular intervals. Patients who fail to achieve a response to 400 mg per day may have their dose increased to 600 mg per day. Authority applications for doses higher than 600 mg per day will not be approved.

A response to treatment is defined as a decrease from baseline in the sum of the products of the perpendicular diameters of all measurable lesions of 50% or greater. (Response definition based on the Southwest Oncology Group standard criteria, see Demetri et al. N Engl J Med 2002; 347: 472-80.)

Applications for continuing treatment may be made by telephone

Note For the following diseases, written authority is required at initiation and for continuation:
Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;
Aggressive systemic mastocytosis with eosinophilia.

imatinib 100 mg tablet, 60

9111M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1286.58	39.50	Glivec [AF]

imatinib 400 mg tablet, 30

9112N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	2486.52	39.50	Glivec [AF]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Myelodysplastic or myeloproliferative disorder

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have confirmed evidence of a platelet-derived growth factor receptor (PDGFR) gene re-arrangement by standard karyotyping; OR
- Patient must have confirmed evidence of a platelet-derived growth factor receptor (PDGFR) gene re-arrangement by fluorescence in situ hybridization (FISH); OR
- Patient must have confirmed evidence of a platelet-derived growth factor receptor (PDGFR) gene re-arrangement by PDGFRB fusion gene transcript, **AND**
- Patient must have previously failed an adequate trial of conventional therapy with cytarabine; OR
- Patient must have previously failed an adequate trial of conventional therapy with etoposide; OR
- Patient must have previously failed an adequate trial of conventional therapy with hydroxyurea, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the pathology report confirming the platelet-derived growth factor receptor (PDGFR) gene re-arrangement; and

(d) a copy of the bone marrow biopsy report which demonstrates the presence of a myelodysplastic or myeloproliferative disorder; and

(e) details of the prior therapy trialled and the response; and

(f) a signed patient acknowledgement

Authority required

Myelodysplastic or myeloproliferative disorder

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The condition must be PDGFRB fusion gene-positive, **AND**
- Patient must must have achieved and maintained a complete haematological response, **AND**
- The condition must not have progressed while receiving PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the full blood examination report which demonstrates a complete haematological response; and

(d) a statement that the disease has not progressed on imatinib therapy

imatinib 100 mg tablet, 60

9176Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9177B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10918P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10939R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Chronic eosinophilic leukaemia or Hypereosinophilic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have confirmed evidence of carrying the FIP1L1-PDGFRA fusion gene, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the pathology report confirming the presence of the FIP1L1-PDGFRA fusion gene; and

(d) a copy of the full blood examination report confirming the presence of hypereosinophilic syndrome or chronic eosinophilic leukaemia; and

(e) details of organ involvement requiring treatment, including a copy of the radiology, nuclear medicine, respiratory function or anatomical pathology reports as appropriate; and

(f) a signed patient acknowledgement

Authority required

Chronic eosinophilic leukaemia or Hypereosinophilic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must must have achieved and maintained a complete haematological response, **AND**
- The condition must not have progressed while receiving PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the full blood examination report which demonstrates a complete haematological response, with a normal eosinophil count; and

(d) a statement that the disease has not progressed on imatinib therapy

imatinib 100 mg tablet, 60

9174W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9175X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10941W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10925B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Dermatofibrosarcoma protuberans

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be unresectable; OR
- The condition must be locally recurrent; OR
- The condition must be metastatic, **AND**
- The treatment must not exceed a maximum dose of 800 mg per day.

(1) Where the application for authority to prescribe is being sought on the basis of unresectable tumour, written evidence in support of that claim must be provided; and

(2) Where the application for authority to prescribe is being sought on the basis of locally recurrent disease, the site of the local recurrence must be specified; and

(3) Where the application for authority to prescribe is being sought on the basis of metastatic disease, the site(s) of metastatic disease must be provided.

Applications for authorisation for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a signed patient acknowledgement

Authority required

Dermatofibrosarcoma protuberans

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be unresectable; OR
- The condition must be locally recurrent; OR
- The condition must be metastatic, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a response to the PBS-subsidised treatment, **AND**
- The condition must not have progressed while receiving PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not exceed a maximum dose of 800 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a statement that the disease has not progressed on imatinib therapy

imatinib 100 mg tablet, 60

9172R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9173T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10942X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10933K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR]	[a] Glivanib [JU]

[a] IMATINIB AN [EA] [a] Imatinib-APOTEX [TX]
[a] IMATINIB-DRLA [RZ] [a] Imatinib GH [GQ]

▪ IMATINIB

Authority required

Gastrointestinal stromal tumour

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be adjuvant to complete surgical resection of primary gastrointestinal stromal tumour (GIST), **AND**
- Patient must be at high risk of recurrence following complete surgical resection of primary GIST, **AND**
- The condition must be histologically confirmed by the detection of CD117 on immunohistochemical staining, **AND**
- The treatment must not exceed a dose of 400 mg per day for a period of 36 months in total (initial plus continuing therapy).

Applications for authorisation of initial treatment must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Imatinib Mesylate (Glivec) PBS Authority Application for Use in Adjuvant Treatment of Gastrointestinal Stromal Tumour - Supporting Information Form which includes the following:

(i) a copy of a pathology report from an Approved Pathology Authority supporting the diagnosis of a gastrointestinal stromal tumour and confirming the presence of CD117 on immunohistochemical staining; and

(ii) a copy of the pathology report must include the size and mitotic rate of the tumour, and the date of tumour resection must be documented, which must not be more than 3 months prior to the date of this application.

High risk of recurrence is defined as:

Primary GIST greater than 5 cm with a mitotic count of greater than 5/50 high power fields (HPF); or

Primary GIST greater than 10 cm with any mitotic rate; or

Primary GIST with a mitotic count of greater than 10/50 HPF.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Any queries concerning patients who are enrolled on the Imatinib Compassionate Program may be directed to the Department of Human Services on 1800 700 270**.**

Authority required

Gastrointestinal stromal tumour

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be adjuvant to complete surgical resection of primary gastrointestinal stromal tumour (GIST), **AND**
- Patient must be at high risk of recurrence following complete surgical resection of primary GIST, **AND**
- The treatment must not exceed a dose of 400 mg per day for a period of 36 months in total (initial plus continuing therapy), **AND**
- Patient must have previously been issued with an authority prescription for imatinib for adjuvant treatment following complete resection of primary GIST.

Applications for continuing therapy may be made by telephone.

Note Authority approval for continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

imatinib 100 mg tablet, 60

5443L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1286.58	39.50	Glivec [AF]

imatinib 400 mg tablet, 30

5444M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2486.52	39.50	Glivec [AF]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Aggressive systemic mastocytosis with eosinophilia

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have confirmed evidence of carrying the FIP1L1-PDGFRA fusion gene, **AND**
- Patient must have previously failed an adequate trial of conventional therapy with corticosteroids; OR
- Patient must have previously failed an adequate trial of conventional therapy with hydroxyurea, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the pathology report confirming the presence of the FIP1L1-PDGFRA fusion gene; and

(d) a copy of the bone marrow biopsy report and/or other tissue biopsy report confirming the diagnosis of aggressive systemic mastocytosis and a copy of the full blood examination report demonstrating eosinophilia; and

(e) details of symptomatic organ involvement requiring treatment, including a copy of the radiology, nuclear medicine, respiratory function or anatomical pathology reports as appropriate; and

(f) details of prior treatment trialled and the response; and

(g) a signed patient acknowledgement

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

Authority required

Aggressive systemic mastocytosis with eosinophilia

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have confirmed evidence of carrying the FIP1L1-PDGFRA fusion gene, **AND**
- Patient must must have achieved and maintained a complete haematological response, **AND**
- The condition must not have progressed while receiving PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not exceed a maximum dose of 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the full blood examination report which demonstrates a complete haematological response; and

(d) a statement that the disease has not progressed on imatinib therapy

Note No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9178C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] Glivec [AF]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9179D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] Glivec [AF]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10940T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10921T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ IMATINIB

Note The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesilate, dasatinib or nilotinib.
Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.
1. Initial First-line treatment From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesilate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure to respond
2. Continuing First-line treatment
Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.
First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.
Second and subsequent authority applications for continuing therapy may be made by telephoning the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason of intolerance. Where there is failure to respond, switching may only occur through application for prescription of second-line agents.Where a patient has previously received PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.
3. Authority approval requirements.Response criteria to initial first-line treatment with imatinib mesilate, dasatinib or nilotinib:For the purposes of assessing response to PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesilate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).
4. Definitions of response
A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.
5. Definitions of loss of response
Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a primary diagnosis of chronic myeloid leukaemia, **AND**
- The condition must be in the chronic phase of chronic myeloid leukaemia, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase, **AND**
- The treatment must be for first line therapy for this condition, **AND**
- Patient must not have previously experienced a failure to respond to the PBS-subsidised treatment with this drug for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with dasatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- The treatment must not exceed a total maximum of 18 months of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form; and(3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and(4) a signed patient acknowledgement form

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.

Patients should be commenced on a dose of imatinib mesilate of 400 mg (base) daily. Continuing therapy is dependent on patients demonstrating a response to imatinib mesilate therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: First Continuing

Clinical criteria:

- The condition must be in the chronic phase of chronic myeloid leukaemia, **AND**
- Patient must have received initial PBS-subsidised treatment with this drug as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with dasatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- Patient must have demonstrated a major cytogenic response; OR
- Patient must have demonstrated a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

First continuing applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a response to treatment as evidenced by either:

(a) a major cytogenetic response [see Note explaining requirements]; or

(b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements].

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Subsequent continuing

Clinical criteria:

- The condition must be in the chronic phase of chronic myeloid leukaemia, **AND**
- Patient must have received initial continuing PBS-subsidised treatment with this drug as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with dasatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with nilotinib as a first line therapy for this condition, **AND**
- Patient must have maintained a major cytogenic response; OR
- Patient must have maintained a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Second and subsequent authority applications for continuing therapy with imatinib mesilate may be made on the telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

imatinib 100 mg tablet, 60

9113P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9114Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10915L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10916M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a primary diagnosis of chronic myeloid leukaemia, **AND**
- The condition must be in the accelerated phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase.

Accelerated phase is defined by the presence of 1 or more of the following:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or

2. Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or

3. Peripheral basophils greater than or equal to 20%; or

4. Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

5. Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome).

Applications for authorisation must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Imatinib Mesilate PBS Authority Application for Use in the Treatment of Chronic Myeloid Leukaemia - Supporting Information form, stating which of the above criteria are satisfied by the patient; and

(c) a copy of the confirming pathology report from an Approved Pathology Authority in the case of criteria (1), (2), (3) and (5) above, or details of the dates of assessments in the case of progressive splenomegaly

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must a primary diagnosis of chronic myeloid leukaemia, **AND**

- The condition must be in the blast phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase.

Blast crisis is defined as either:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or

2. Extramedullary involvement other than spleen and liver.

Applications for authorisation must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Imatinib Mesilate PBS Authority Application for Use in the Treatment of Chronic Myeloid Leukaemia - Supporting Information form, stating which of the above criteria are satisfied by the patient; and

(c) a copy of the confirming pathology report from an Approved Pathology Authority in the case of criterion (1) above, or details of the date of assessment in the case of extramedullary involvement

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The condition must be in the accelerated phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The condition must be in the blast phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase.

imatinib 100 mg tablet, 60

9115R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9116T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10920R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10935M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ IMATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Allogeneic stem cell transplantation is the preferred therapy for eligible patients achieving a complete remission of Philadelphia positive acute lymphoblastic leukaemia.

Note No applications for increased repeats will be authorised.

Note Pharmaceutical benefits that have the form imatinib tablet 100 mg and imatinib capsule 100 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form imatinib tablet 400 mg and imatinib capsule 400 mg are equivalent for the purposes of substitution.

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be newly diagnosed, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- The treatment must be for induction and consolidation therapy, **AND**
- The treatment must be in combination with chemotherapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Acute Lymphoblastic Leukaemia Imatinib PBS Authority Application - Supporting Information Form; and

(c) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of acute lymphoblastic leukaemia to confirm eligibility for treatment, with either cytogenetic evidence of the Philadelphia chromosome, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow. (The date of the relevant pathology report needs to be provided); and

(d) a signed patient acknowledgement

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- Patient must have previously received treatment with this drug for this condition under Imatinib Compassionate Program.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Acute Lymphoblastic Leukaemia Imatinib PBS Authority Application - Supporting Information Form; and

(c) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of acute lymphoblastic leukaemia to confirm eligibility for treatment, with either cytogenetic evidence of the Philadelphia chromosome, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow. (The date of the relevant pathology report needs to be provided); and

(d) a signed patient acknowledgement

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL, **AND**
- The treatment must be for maintenance of first complete remission, **AND**
- The treatment must be in combination with chemotherapy.

Imatinib is available with a lifetime maximum of 24 months for continuing treatment with imatinib therapy for patients with acute lymphoblastic leukaemia reimbursed through the PBS.

Note Any queries concerning the arrangements to prescribe this drug beyond 24 months may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

imatinib 100 mg tablet, 60

9123E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	1286.58	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 400 mg tablet, 30

9124F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	2486.52	39.50	[a] Glivec [AF] [a] Imatinib-Teva [TB]	[a] IMATINIB RBX [RA]

imatinib 100 mg capsule, 60

10924Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	1286.58	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

imatinib 400 mg capsule, 30

10917N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	2486.52	39.50	[a] CIPLA IMATINIB ADULT [LR] [a] IMATINIB AN [EA] [a] IMATINIB-DRLA [RZ]	[a] Glivanib [JU] [a] Imatinib-APOTEX [TX] [a] Imatinib GH [GQ]

▪ LAPATINIB

Note No applications for increased maximum quantities will be authorised.

Note No applications for increased repeats will be authorised.

Authority required

Metastatic (Stage IV) HER2 positive breast cancer

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have evidence of human epidermal growth factor receptor 2 (HER2) gene amplification as demonstrated by in situ hybridisation (ISH) either in the primary tumour or a metastatic lesion, **AND**
- The treatment must be in combination with capecitabine, **AND**
- Patient must have received prior therapy with a taxane for at least 3 cycles; OR
- Patient must have developed intolerance to treatment with a taxane of a severity necessitating permanent treatment withdrawal, **AND**
- The condition must have progressed following treatment with pertuzumab and trastuzumab in combination, **AND**
- The treatment must be the sole PBS-subsidised anti-HER2 therapy for this condition, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure.

Authority applications for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Late stage metastatic breast cancer Initial PBS authority application form which includes:

(i) a copy of the pathology report from an Approved Pathology Authority confirming evidence of HER2 gene amplification in the primary tumour or a metastatic lesion by in situ hybridisation (ISH) and tick a box to state the person has Stage IV disease;

(ii) date of last treatment with a taxane and total number of cycles;

(iii) a copy of the signed patient acknowledgement form;

(iv) dates of treatment with trastuzumab and pertuzumab; and

(v) date of demonstration of progression whilst on treatment with trastuzumab and pertuzumab.

Cardiac function must be tested by echocardiography (ECHO) or multigated acquisition (MUGA), prior to seeking the initial authority approval and then at 3 monthly intervals during treatment.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Metastatic (Stage IV) HER2 positive breast cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- The treatment must be in combination with capecitabine, **AND**
- Patient must not receive PBS-subsidised treatment with this drug if progressive disease develops while on this drug, **AND**
- The treatment must be the sole PBS-subsidised anti-HER2 therapy for this condition, **AND**
- The treatment must not be used in a patient with a left ventricular ejection fraction (LVEF) of less than 45% and/or with symptomatic heart failure.

Cardiac function must be tested by echocardiography (ECHO) or multigated acquisition (MUGA), at 3 monthly intervals during treatment.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

The treatment must not exceed a lifetime total of one continuous course.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

lapatinib 250 mg tablet, 70

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9148L	2	2	..	*3228.57	39.50	Tykerb [NV]

▪ LENVATINIB

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6604

Locally advanced or metastatic differentiated thyroid cancer

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be refractory to radioactive iodine, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have symptomatic progressive disease prior to treatment; OR
- Patient must have progressive disease at critical sites with a high risk of morbidity or mortality where local control cannot be achieved by other measures, **AND**
- Patient must have thyroid stimulating hormone adequately repressed, **AND**
- Patient must be one in whom surgery is inappropriate, **AND**
- Patient must not be a candidate for radiotherapy with curative intent, **AND**
- Patient must have a WHO performance status of 2 or less.

Radioactive iodine refractory is defined as:

- a lesion without iodine uptake on a radioactive iodine (RAI) scan; or
- having received a cumulative RAI dose of greater than or equal to 600 mCi; or
- progression within 12 months of a single RAI treatment; or
- progression after two RAI treatments administered within 12 months of each other.

Authority required (STREAMLINED)

6578

Locally advanced or metastatic differentiated thyroid cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be refractory to radioactive iodine, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST).

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

Authority required (STREAMLINED)

6577

Locally advanced or metastatic differentiated thyroid cancer

Treatment Phase: Grandfathering treatment

Clinical criteria:

- The condition must be refractory to radioactive iodine, **AND**
- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 December 2016, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have thyroid stimulating hormone adequately repressed.

lenvatinib 4 mg capsule, 30

10952K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	3304.52	39.50	Lenvima [EI]

lenvatinib 10 mg capsule, 30

10965D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	2	..	*6459.53	39.50	Lenvima [EI]

▪ NILOTINIB

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be a primary diagnosis, **AND**
- The condition must be in the chronic phase, **AND**
- The condition must be expressing the Philadelphia chromosome; OR
- The condition must have the transcript BCR-ABL tyrosine kinase, **AND**
- The treatment must be for first line therapy for this condition, **AND**
- Patient must not have previously experienced a failure to respond to the PBS-subsidised first line treatment with this drug for this condition; OR

- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to initial PBS-subsidised treatment with dasatinib as a first line therapy for this condition, **AND**
- The treatment must not exceed a total maximum of 18 months of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.Patients should be commenced on a dose of nilotinib of 300 mg twice daily. Continuing therapy is dependent on patients demonstrating a response to nilotinib therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form; and(3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and(4) a signed patient acknowledgement formThe following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesilate, dasatinib or nilotinib.

Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.

1. Initial First-line treatment From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesilate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure to respond 2. Continuing First-line treatment -

Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.

First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.

Second and subsequent authority applications for continuing therapy may be made by telephoning the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason ofintolerance. Where there is failure to respond, switching may only occur through application for prescription of second-line agents.Where a patient has previously received PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.

3. Authority approval requirements.Response criteria to initial first-line treatment with imatinib mesilate, dasatinib or nilotinib:For the purposes of assessing response to PBS-subsidised treatment with imatinib mesilate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesilate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

4. Definitions of response.A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

5. Definitions of loss of response.Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: First continuing treatment

Clinical criteria:

- The condition must be in the chronic phase, **AND**
- Patient must have received initial PBS-subsidised first line treatment with this drug for this condition; OR

- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to first continuing PBS-subsidised treatment with dasatinib as a first line therapy for this condition, **AND**
- Patient must have demonstrated a major cytogenic response; OR
- Patient must have demonstrated a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

First continuing applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) demonstration of continued response to treatment as evidenced by either:(a) a major cytogenetic response [see Note explaining requirements]; or(b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements].Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Subsequent continuing treatment

Clinical criteria:

- The condition must be in the chronic phase, **AND**
- Patient must have received the First continuing PBS-subsidised treatment with this drug as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with imatinib as a first line therapy for this condition; OR
- Patient must have experienced intolerance, not a failure to respond, to subsequent continuing PBS-subsidised treatment with dasatinib as a first line therapy for this condition, **AND**
- Patient must have maintained a major cytogenic response; OR
- Patient must have maintained a peripheral blood level of BCR-ABL of less than 1%, **AND**
- The treatment must not exceed a total maximum of 24 weeks of therapy with a PBS-subsidised treatment with a tyrosine kinase inhibitor for this condition under this restriction, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Subsequent authority applications for continuing therapy with this drug may be made by telephoning the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NILOTINIB Capsule 150 mg (as hydrochloride monohydrate), 120

1309X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	4254.95	39.50	Tasigna [NV]

▪ NILOTINIB

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be in the chronic phase; OR
- The condition must be in the accelerated phase, **AND**
- Patient must have failed an adequate trial of PBS-subsidised first line treatment with imatinib for this condition; OR
- Patient must have failed an adequate trial of PBS-subsidised first line treatment with dasatinib for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Failure of an adequate trial of imatinib or dasatinib is defined as:(i) Lack of response to initial imatinib or dasatinib therapy, defined as either:- failure to achieve a haematological response after a minimum of 3 months therapy with imatinib or dasatinib for patients initially treated in chronic phase; or- failure to achieve any cytogenetic response after a minimum of 6 months therapy with imatinib or dasatinib for patients initially treated in chronic phase as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or- failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with imatinib or dasatinib; OR(ii) Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing imatinib or dasatinib therapy; OR(iii) Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing imatinib or dasatinib therapy; OR(iv) Development of accelerated phase in a patient previously prescribed imatinib or dasatinib for the chronic phase of chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or(2) Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or(3) Peripheral basophils greater than or equal to 20%; or(4) Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or(5) Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome); OR(v) Disease progression (defined as a greater than or equal to.50% increase in peripheral white blood cell count, blast count, basophils or platelets) during first-line imatinib or dasatinib therapy in patients with accelerated phase chronic myeloid leukaemia, provided that blast crisis has been excluded on bone marrow biopsy.

Patients should be commenced on a dose of nilotinib of 400 mg twice daily. Continuing therapy is dependent on patients demonstrating a major cytogenetic response to nilotinib therapy or a peripheral blood BCR-ABL level of less than 1% within 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:(a) a completed authority prescription form; and(b) a completed Chronic Myeloid Leukaemia - Second and Third Line - Supporting Information Form; and(c) a signed patient acknowledgement; and(d) a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale. (The date of the relevant pathology report needs to be provided); and(e) where there has been a loss of response to imatinib or dasatinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement.

Note The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for all phases of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to dasatinib or nilotinib. Imatinib mesilate is not approved for use in second or third line treatment.Patients are eligible for PBS-subsidised treatment with only one of dasatinib or nilotinib at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between these agents if they have not failed prior PBS-subsidised treatment with that agent.Nilotinib is not approved for patients in blast crisis.1. Initial second line treatmentFrom 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib within the initial 18 month treatment period as second-line therapy, as long as only one agent is approved at a time and providing the patient did not fail that drug as first-line therapy.During the initial 18 month treatment period, switching between approved second-line agents may only occur for reasons of intolerance, not failure of response.2. Initial third line treatmentThird-line treatment with a TKI can only be approved when imatinib is used for first-line treatment. Patients will only be approved for PBS-subsidised treatment with one third-line agent.From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib providing the patient did not fail that drug as first or second line therapy and for nilotinib the patient is not in blast crisis.3. Continuing treatment for second and third line treatmentAll continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.During second line continuing treatment beyond the initial 18 month treatment period, switching between approved second line TKI agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of a third line agent.4. Authority approval requirements.Response criteria to initial treatment with dasatinib or nilotinib:For the purposes of assessing response to PBS-subsidised treatment with dasatinib or nilotinib, either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).5. Definitions of response.A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.6. Definitions of loss of response.Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a major cytogenetic response to nilotinib in the preceding 18 months and thereafter at 12 monthly intervals; OR
- Patient must have achieved a peripheral blood level of BCR-ABL of less than 1% to nilotinib in the preceding 18 months and thereafter at 12 monthly intervals, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed Chronic Myeloid Leukaemia - Second and Third Line - Application Form for continuing treatment; and(3) demonstration of continued response to treatment as evidenced by either:(a) major cytogenetic response [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided; or(b) a peripheral blood level of BCR-ABL of

less than 1% on the international scale [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided

NILOTINIB Capsule 200 mg (as hydrochloride monohydrate), 120

9171Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5589.01	39.50	Tasigna [NV]

▪ NINTEDANIB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Initial treatment 1 - new patient

Clinical criteria:

- The condition must be diagnosed through a multidisciplinary team, **AND**
- Patient must have chest high resolution computed tomography (HRCT) consistent with diagnosis of idiopathic pulmonary fibrosis within the previous 12 months, **AND**
- Patient must have a forced vital capacity (FVC) greater than or equal to 50% predicted for age, gender and height, **AND**
- Patient must have a forced expiratory volume in 1 second to forced vital capacity ratio (FEV1/FVC) greater than 0.7, **AND**
- Patient must have diffusing capacity of the lungs for carbon monoxide (DLCO) corrected for haemoglobin equal to or greater than 30%, **AND**
- Patient must not have interstitial lung disease due to other known causes including domestic and occupational environmental exposures, connective tissue disease, or drug toxicity, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

A multidisciplinary team is defined as comprising of at least a specialist respiratory physician, a radiologist and where histological material is considered, a pathologist. If attendance is not possible because of geographical isolation, consultation with a multidisciplinary team is required for diagnosis.

Patient must have not have an acute respiratory infection at the time of FVC testing.

Applications for authorisation of initial treatment must be in writing and must include:

a) a completed authority prescription form; and

b) a completed IPF Authority Application Supporting Information Form; and

c) a signed patient acknowledgement.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Initial treatment 2 - change or re-commencement of treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with nintedanib or pirfenidone for this condition, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Initial treatment 3 - Grandfathering treatment

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 May 2017, **AND**
- The condition must have been diagnosed through a multidisciplinary team, **AND**
- Patient must have had a forced vital capacity (FVC) greater than or equal to 50% predicted for age, gender and height at the time treatment with this drug for this condition was initiated, **AND**
- Patient must have had a forced expiratory volume in 1 second (FEV1)/FVC ratio greater than 0.7 at the time treatment with this drug for this condition was initiated, **AND**
- Patient must have had diffusing capacity of the lungs for carbon monoxide (DLCO) corrected for haemoglobin equal to or greater than 30% at the time treatment with this drug for this condition was initiated, **AND**
- Patient must not have interstitial lung disease due to other known causes including domestic and occupational environmental exposures, connective tissue disease, or drug toxicity, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

A multidisciplinary team is defined as comprising of at least a specialist respiratory physician, a radiologist and where histological material is considered, a pathologist. If attendance is not possible because of geographical isolation, consultation with a multidisciplinary team is required for diagnosis.

Patient must have not have an acute respiratory infection at the time of FVC testing.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Applications for authorisation of initial treatment must be in writing and must include:

a) a completed authority prescription form; and

b) a completed IPF Authority Application Supporting Information Form; and

c) a signed patient acknowledgement.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

nintedanib 100 mg capsule, 60

11100F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1752.64	39.50	Ofev [BY]

nintedanib 150 mg capsule, 60

11106M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	3387.12	39.50	Ofev [BY]

▪ PAZOPANIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must have received prior chemotherapy treatment including an anthracycline, **AND**
- Patient must not have received prior treatment with an angiogenesis inhibitor, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patient must not have any of the following conditions:

adipocytic soft tissue sarcoma;

gastrointestinal stromal tumour (GIST);

rhabdomyosarcoma other than alveolar or pleomorphic;

chondrosarcoma;

osteosarcoma;
Ewings tumour/primitive neuroectodermal tumour;
dermofibromatosis sarcoma protuberans;
inflammatory myofibroblastic sarcoma;
malignant mesothelioma;
mixed mesodermal tumour of the uterus.
The authority application must be made in writing.

pazopanib 400 mg tablet, 60

10041L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	4676.80	39.50	Votrient [NV]

pazopanib 200 mg tablet, 90

10042M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	3544.98	39.50	Votrient [NV]

▪ PAZOPANIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

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

Note Special Pricing Arrangements apply.

Authority required

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

- Patient must have previously been issued with an authority prescription for pazopanib, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for continuing therapy may be made by telephone.

pazopanib 400 mg tablet, 60

10043N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	4676.80	39.50	Votrient [NV]

pazopanib 200 mg tablet, 90

10047T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	3544.98	39.50	Votrient [NV]

▪ PAZOPANIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

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

Note Special Pricing Arrangements apply.

Authority required

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

- Patient must have previously been issued with an authority prescription for pazopanib, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- Patient must require dose adjustment, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for continuing therapy may be made by telephone.

pazopanib 400 mg tablet, 30

10052C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2413.16	39.50	Votrient [NV]

pazopanib 200 mg tablet, 30

10054E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1248.61	39.50	Votrient [NV]

▪ PAZOPANIB

Note Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.
Note Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.
Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.
Note Special Pricing Arrangements apply.

Authority required
Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Continuing treatment beyond 3 months
Clinical criteria:

- Patient must have previously been issued with an authority prescription for pazopanib, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- Patient must require dose adjustment, **AND**
- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

pazopanib 400 mg tablet, 30

2201W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2413.16	39.50	Votrient [NV]

pazopanib 200 mg tablet, 30

2232L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1248.61	39.50	Votrient [NV]

▪ PAZOPANIB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.
Note Patients who have developed intolerance to sunitinib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised pazopanib.
Note Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.

Authority required
Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Initial treatment
Clinical criteria:

- Patient must meet the Memorial Sloan Kettering Cancer Centre (MSKCC) low to intermediate risk group criteria, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

pazopanib 400 mg tablet, 60

2030W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	4676.80	39.50	Votrient [NV]

pazopanib 200 mg tablet, 90

2029T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	3544.98	39.50	Votrient [NV]

▪ PAZOPANIB

Note Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.
Note Special Pricing Arrangements apply.

Authority required
Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Continuing treatment beyond 3 months
Clinical criteria:

- Patient must have previously been issued with an authority prescription for pazopanib, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Note Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have been receiving treatment with pazopanib prior to 1 October 2012, **AND**
- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

pazopanib 400 mg tablet, 60

2035D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	4676.80	39.50	Votrient [NV]

pazopanib 200 mg tablet, 90

2034C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	3544.98	39.50	Votrient [NV]

▪ PONATINIB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Patients are eligible for PBS-subsidised treatment with only one of imatinib, dasatinib, nilotinib or ponatinib at any one time and must not be receiving concomitant interferon alfa therapy.
1. Continuing treatment
All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:
(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and
(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.
2. Authority approval requirements.
Response criteria to initial treatment with ponatinib:
For the purposes of assessing response to PBS-subsidised treatment with ponatinib, either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with dasatinib, nilotinib or ponatinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).
3. Definitions of response.
A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.
A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.
4. Definitions of loss of response.
Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor therapy.
Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have failed an adequate trial of dasatinib; OR
- Patient must have developed intolerance to dasatinib of a severity necessitating permanent treatment withdrawal, **AND**

- Patient must have failed an adequate trial of nilotinib; OR
- Patient must have developed intolerance to nilotinib of a severity necessitating permanent treatment withdrawal; OR
- Patient must not be eligible for PBS-subsidised treatment with nilotinib because the patient has a blast crisis.

Failure of an adequate trial of dasatinib or nilotinib is defined as:

1. Lack of response to dasatinib or nilotinib therapy, defined as either:

(i) failure to achieve a haematological response after a minimum of 3 months therapy with dasatinib or nilotinib; or

(ii) failure to achieve any cytogenetic response after a minimum of 6 months therapy with dasatinib or nilotinib as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or

(iii) failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with dasatinib or nilotinib; OR

2. Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing dasatinib or nilotinib therapy; OR

3. Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing dasatinib or nilotinib therapy; OR

4. Development of accelerated phase or blast crisis in a patient previously prescribed dasatinib or nilotinib for any phase of chronic myeloid leukaemia; OR

5. Disease progression (defined as a greater than or equal to 50% increase in peripheral white blood cell count, blast count, basophils or platelets) during dasatinib or nilotinib therapy in patients with accelerated phase or blast crisis chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or

2. Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or

3. Peripheral basophils greater than or equal to 20%; or

4. Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

5. Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome).

Blast crisis is defined as either:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or

2. Extramedullary involvement other than spleen and liver.

The authority application must be made in writing and must include:

1. a completed authority prescription form;

2. a completed Chronic Myeloid Leukaemia - ponatinib Initial PBS authority application form;

3. a signed patient acknowledgement;

4. a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale. (The date of the relevant pathology report, which should be within the previous 6 months, needs to be provided); and

5. where there has been a loss of response to dasatinib or nilotinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must be expressing the T315I mutation, **AND**
- Patient must have failed an adequate trial of imatinib; OR
- Patient must have failed an adequate trial of dasatinib; OR
- Patient must have failed an adequate trial of nilotinib.

Failure of an adequate trial of imatinib or dasatinib or nilotinib is defined as:

1. Lack of response to imatinib or dasatinib or nilotinib therapy, defined as either:

(i) failure to achieve a haematological response after a minimum of 3 months therapy with imatinib or dasatinib or nilotinib; or

(ii) failure to achieve any cytogenetic response after a minimum of 6 months therapy with imatinib or dasatinib or nilotinib as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or

(iii) failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with imatinib or dasatinib or nilotinib; OR

2. Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing imatinib or dasatinib or nilotinib therapy; OR

3. Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing imatinib or dasatinib or nilotinib therapy; OR

4. Development of accelerated phase or blast crisis in a patient previously prescribed imatinib or dasatinib or nilotinib for any phase of chronic myeloid leukaemia; OR

5. Disease progression (defined as a greater than or equal to 50% increase in peripheral white blood cell count, blast count, basophils or platelets) during imatinib or dasatinib or nilotinib therapy in patients with accelerated phase or blast crisis chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or

2. Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or

3. Peripheral basophils greater than or equal to 20%; or

4. Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

5. Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome).

Blast crisis is defined as either:

1. Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or

2. Extramedullary involvement other than spleen and liver.

The authority application must be made in writing and must include:

1. a completed authority prescription form; and

2. a completed Chronic Myeloid Leukaemia - ponatinib Initial PBS authority application form; and

3. a signed patient acknowledgement; and

4. a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale and evidence of the T315I mutation. (The date of the relevant pathology report(s), which should be within the previous 6 months, need(s) to be provided); and

5. where there has been a loss of response to imatinib or dasatinib or nilotinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement.

Authority required

Chronic Myeloid Leukaemia (CML)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have demonstrated either a major cytogenetic response, or less than 1% BCR-ABL level in the blood, to ponatinib within 18 months of commencement and at no greater than 12 month intervals thereafter.

Applications for authorisation must be in writing and must include:

1. a completed authority prescription form; and

2. a completed Chronic Myeloid Leukaemia Continuing PBS authority application Supporting information form; and

3. demonstration of continued response to treatment as evidenced by either:

(a) major cytogenetic response [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided; or

(b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided.

ponatinib 15 mg tablet, 60

10520Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5758.13	39.50	Iclusig [TS]

ponatinib 45 mg tablet, 30

10530F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	6477.57	39.50	Iclusig [TS]

▪ PONATINIB

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must be expressing the T315I mutation, **AND**
- Patient must have failed treatment with chemotherapy, with or without another tyrosine kinase inhibitor, **AND**
- Patient must have failed allogeneic haemopoietic stem cell transplantation (where appropriate).

Failure of treatment is defined as either:

1. Failure to achieve a complete morphological and cytogenetic remission after a minimum of 2 months treatment with intensive chemotherapy, with or without another tyrosine kinase inhibitor;

2. Morphological or cytogenetic relapse of leukaemia after achieving a complete remission induced by chemotherapy, with or without another tyrosine kinase inhibitor;

3. Morphological or cytogenetic relapse or persistence of leukaemia after allogeneic haemopoietic stem cell transplantation.

Patients must have active leukaemia, as defined by presence on current pathology assessments of either morphological infiltration of the bone marrow (greater than 5% lymphoblasts) or cerebrospinal fluid or other sites; OR the presence of cells bearing the Philadelphia chromosome on cytogenetic or FISH analysis in the bone marrow of patients in morphological remission.

The authority application must be made in writing and must include:

1. a completed authority prescription form; and

2. a completed Acute Lymphoblastic Leukaemia - ponatinib Initial PBS authority application form; and

3. a signed patient acknowledgement; and

4. a pathology report demonstrating that the patient has active acute lymphoblastic leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or morphological evidence of acute lymphoblastic leukaemia plus qualitative RT-PCR evidence of BCR-ABL transcript.; and evidence of the T315I mutation. The date of the relevant pathology report(s), which should be within the previous 6 months, need(s) to be provided

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acute lymphoblastic leukaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must not have progressive disease.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ponatinib 15 mg tablet, 60

10523W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	5758.13	39.50	Iclusig [TS]

ponatinib 45 mg tablet, 30

10524X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	6477.57	39.50	Iclusig [TS]

▪ RUXOLITINIB

Note Risk of myelofibrosis is defined in accordance with the Myelofibrosis International Prognostic Scoring System (IPSS) OR the Dynamic International Prognostic Scoring System (DIPSS) OR the Age-Adjusted DIPSS.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity may be authorised for the 15 mg and 20 mg dose strengths.

Note Special Pricing Arrangements apply.

Authority required

High risk and intermediate-2 risk myelofibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition.

Authority required

Intermediate-1 risk myelofibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition.

ruxolitinib 20 mg tablet, 56

10617T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5149.52	39.50	Jakavi [NV]

ruxolitinib 5 mg tablet, 56

10616R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*5149.53	39.50	Jakavi [NV]

ruxolitinib 10 mg tablet, 56

10927D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5149.52	39.50	Jakavi [NV]

ruxolitinib 15 mg tablet, 56

10615Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	5149.52	39.50	Jakavi [NV]

▪ RUXOLITINIB

Note Risk of myelofibrosis is defined in accordance with the Myelofibrosis International Prognostic Scoring System (IPSS) OR the Dynamic International Prognostic Scoring System (DIPSS) OR the Age-Adjusted DIPSS.

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Programs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity may be authorised for the 15 mg and 20 mg dose strengths.

Note Special Pricing Arrangements apply.

Authority required

High risk and intermediate-2 risk myelofibrosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis.

Note The authority application must be made in writing and must include:
(1) A completed authority prescription form; and
(2) A completed Myelofibrosis Authority Application Supporting Information Form, which includes all of the following:
(a) A copy of the bone marrow biopsy report confirming diagnosis of myelofibrosis; and
(b) A classification of risk of myelofibrosis according to either the IPSS, DIPSS, or the Age-Adjusted DIPSS.

Authority required

Intermediate-1 risk myelofibrosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis, **AND**
- Patient must have severe disease-related symptoms that are resistant, refractory or intolerant to available therapy.

Note The authority application must be made in writing and must include:
(1) A completed authority prescription form; and
(2) A completed Myelofibrosis Authority Application Supporting Information Form, which includes all of the following:
a) A copy of the bone marrow biopsy report confirming diagnosis of myelofibrosis;
b) A classification of risk of myelofibrosis according to either the IPSS, DIPSS, or the Age-Adjusted DIPSS; and
c) A confirmation that the patient's disease related symptoms are resistant, refractory or intolerant to available therapy.

ruxolitinib 20 mg tablet, 56

10618W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	5149.52	39.50	Jakavi [NV]

ruxolitinib 5 mg tablet, 56

10614P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*5149.53	39.50	Jakavi [NV]

ruxolitinib 10 mg tablet, 56

10913J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	5149.52	39.50	Jakavi [NV]

ruxolitinib 15 mg tablet, 56

10619X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	5149.52	39.50	Jakavi [NV]

▪ SORAFENIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have progressive disease according to the Response Evaluation Criteria In Solid Tumours (RECIST) following first-line treatment with a tyrosine kinase inhibitor, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have developed intolerance to a tyrosine kinase inhibitor of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised treatment with this drug.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

sorafenib 200 mg tablet, 60

10226F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	2	..	*6144.71	39.50	Nexavar [BN]

▪ SORAFENIB

Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.

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

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

Note Special Pricing Arrangements apply.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

sorafenib 200 mg tablet, 60

10242C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*6144.71	39.50	Nexavar [BN]

▪ SORAFENIB

Note Sorafenib is not PBS-subsidised for adjunctive treatment after resection, ablation or chemoembolization.
Sorafenib is not PBS-subsidised for maintenance therapy after disease progression.

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

4230

Advanced Barcelona Clinic Liver Cancer Stage C hepatocellular carcinoma

Treatment Phase: Initial

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must have Child Pugh class A.

Authority required (STREAMLINED)

4234

Advanced Barcelona Clinic Liver Cancer Stage C hepatocellular carcinoma

Treatment Phase: Continuing

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been treated with PBS-subsidised sorafenib, **AND**
- Patient must not have progressive disease.

sorafenib 200 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9380Q	2	2	..	*6144.71	39.50	Nexavar [BN]

▪ SUNITINIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be symptomatic (despite somatostatin analogues); OR
- Patient must have disease progression, **AND**
- The treatment must be as monotherapy.

Disease progression must be documented in the patient's medical records.

Patients who have developed progressive disease on everolimus are not eligible to receive PBS-subsidised sunitinib for this condition.

Patients who have developed intolerance to everolimus of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised sunitinib.

sunitinib 37.5 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10464R	1	2	..	4959.60	39.50	Sutent [PF]

sunitinib 50 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2837H	1	2	..	6563.05	39.50	Sutent [PF]

sunitinib 12.5 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10004M	1	2	..	1736.75	39.50	Sutent [PF]

sunitinib 25 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2959R	1	2	..	3356.15	39.50	Sutent [PF]

▪ SUNITINIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have disease progression, **AND**
- The treatment must be as monotherapy.

Patients who have progressive disease with this drug are no longer eligible for PBS-subsidised treatment with this drug.

sunitinib 37.5 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10473F	1	5	..	4959.60	39.50	Sutent [PF]

sunitinib 50 mg capsule, 28

10010W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	6563.05	39.50	Sutent [PF]

sunitinib 12.5 mg capsule, 28

10009T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1736.75	39.50	Sutent [PF]

sunitinib 25 mg capsule, 28

2842N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	3356.15	39.50	Sutent [PF]

▪ SUNITINIB

Note Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.
Note Patients who have developed progressive disease on pazopanib are not eligible to receive PBS-subsidised sunitinib.
Note Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:
Complete response (CR) is disappearance of all target lesions.
Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.
Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.
Stable disease (SD) is small changes that do not meet above criteria.
Note Special Pricing Arrangements apply.

Authority required
Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Continuing treatment beyond 3 months
Clinical criteria:

- Patient must have previously been issued with an authority prescription for sunitinib, **AND**
- Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**
- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

sunitinib 37.5 mg capsule, 28

10459L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	4959.60	39.50	Sutent [PF]

sunitinib 50 mg capsule, 28

9422X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	6563.05	39.50	Sutent [PF]

sunitinib 12.5 mg capsule, 28

9420T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1736.75	39.50	Sutent [PF]

sunitinib 25 mg capsule, 28

9421W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	3356.15	39.50	Sutent [PF]

▪ SUNITINIB

Note Patients who have developed intolerance to pazopanib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised sunitinib.
Note Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Initial treatment
Clinical criteria:

- Patient must meet the Memorial Sloan Kettering Cancer Centre (MSKCC) low to intermediate risk group criteria, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Patients who have developed progressive disease on pazopanib are not eligible to receive PBS-subsidised sunitinib.

sunitinib 37.5 mg capsule, 28

10504W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	4959.60	39.50	Sutent [PF]

sunitinib 50 mg capsule, 28

9419R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	6563.05	39.50	Sutent [PF]

sunitinib 12.5 mg capsule, 28

9417P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1736.75	39.50	Sutent [PF]

sunitinib 25 mg capsule, 28

9418Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	3356.15	39.50	Sutent [PF]

▪ SUNITINIB

Note Sunitinib malate is not PBS-subsidised for the treatment of patients with resectable malignant gastrointestinal stromal tumours.

Note Any queries concerning patients who are enrolled on the Sunitinib Compassionate Program may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

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

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

Note Special Pricing Arrangements apply.

Authority required

Metastatic or unresectable malignant gastrointestinal stromal tumour

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must have previously failed or be intolerant to imatinib mesylate.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Sunitinib Malate (Sutent) PBS Authority Application for Use in the Treatment of Gastrointestinal Stromal Tumour - Supporting Information Form; and

(3) a signed patient acknowledgement.

Patients who have failed to respond or are intolerant to imatinib are no longer eligible to receive PBS-subsidised imatinib

Authority required

Metastatic or unresectable malignant gastrointestinal stromal tumour

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- The treatment must be as monotherapy, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must not have progressive disease.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.

Note Patients who have failed to respond or are intolerant to imatinib are no longer eligible to receive PBS subsidised imatinib after progression on this drug

sunitinib 37.5 mg capsule, 28

10503T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	4959.60	39.50	Sutent [PF]

sunitinib 50 mg capsule, 28

9490L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	6563.05	39.50	Sutent [PF]

sunitinib 12.5 mg capsule, 28

9488J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1736.75	39.50	Sutent [PF]

sunitinib 25 mg capsule, 28

9489K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	3356.15	39.50	Sutent [PF]

▪ TRAMETINIB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)
6778
Unresectable Stage III or Stage IV malignant melanoma
Treatment Phase: Initial treatment
Clinical criteria:

- Patient must be receiving PBS-subsidised dabrafenib concomitantly for this condition, **AND**
- Patient must not have had progressive disease when treated with a BRAF inhibitor.

trametinib 500 microgram tablet, 30

10403M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	3	..	*6608.62	39.50	Mekinist [NV]

trametinib 2 mg tablet, 30

10382K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	8761.69	39.50	Mekinist [NV]

▪ TRAMETINIB

Note A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)
6752
Unresectable Stage III or Stage IV malignant melanoma
Treatment Phase: Continuing treatment
Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must be receiving PBS-subsidised dabrafenib concomitantly for this condition, **AND**
- Patient must have stable or responding disease.

trametinib 500 microgram tablet, 30

10385N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*6608.62	39.50	Mekinist [NV]

trametinib 2 mg tablet, 30

10405P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	8761.69	39.50	Mekinist [NV]

▪ VEMURAFENIB

Note A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)
6044
Unresectable Stage III or Stage IV malignant melanoma
Treatment Phase: Initial treatment
Clinical criteria:

- The condition must be positive for a BRAF V600 mutation, **AND**
- The condition must not have been treated previously with PBS subsidised therapy; OR
- Patient must have developed intolerance to another BRAF inhibitor of a severity necessitating permanent treatment withdrawal, **AND**
- Patient must have a WHO performance status of 2 or less.

vemurafenib 240 mg tablet, 56

11076Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	3	..	*8187.59	39.50	Zelboraf [RO]

▪ VEMURAFENIB

Note A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

Note A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.

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

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

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6013

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must have stable or responding disease.

vemurafenib 240 mg tablet, 56

11081F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	5	..	*8187.59	39.50	Zelboraf [RO]

Other antineoplastic agents

▪ HYDROXYCARBAMIDE (HYDROXYUREA)

hydroxycarbamide (hydroxyurea) 500 mg capsule, 100

3093T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	71.58	39.50	Hydrea [BQ]

▪ IDELALISIB

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

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

Note Special Pricing Arrangements apply.

Authority required

Chronic lymphocytic leukaemia (CLL) or small lymphocytic lymphoma (SLL)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be in combination with rituximab for up to a maximum of 8 doses, followed by monotherapy, **AND**
- The condition must have relapsed or be refractory to at least one prior therapy, **AND**
- The condition must be CD20 positive, **AND**
- Patient must have a total cumulative illness rating scale (CIRS) score of greater than 6 (excluding CLL-induced illness or organ damage), **AND**
- Patient must be inappropriate for chemo-immunotherapy.

A patient can be considered inappropriate for chemo-immunotherapy when one or more of the following are experienced:

1. Severe neutropenia defined as absolute neutrophil count of less than or equal to 1.0 x 10^9/L; or

2. Severe thrombocytopenia defined as platelet count of less than or equal to 50 x 10^9/L; or

3. Evidence of one or more 17p chromosomal deletions demonstrated by fluorescence in situ hybridisation (FISH).

Full blood count results must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

a) A completed authority prescription form;

b) A completed CLL/SLL PBS Authority Application - Supporting information form; and

c) Pathology report indicating that the patient can be considered inappropriate for chemo-immunotherapy due to one or more of the following:

1) Recent severe neutropenia; or

2) Recent severe thrombocytopenia; or

3) Presence of 17p chromosomal deletion using fluorescence in situ hybridisation (FISH).

A Grandfathered patient who has previously received non-PBS subsidised treatment with this drug for this condition prior to 1 September 2017 must have met all the initial restriction criteria prior to initiating non-PBS subsidised treatment. A Grandfathered patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available

on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic lymphocytic leukaemia (CLL) or small lymphocytic lymphoma (SLL)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

idelalisib 100 mg tablet, 60

11170X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5367.27	39.50	Zydelig [GI]

idelalisib 150 mg tablet, 60

11162L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5367.27	39.50	Zydelig [GI]

▪ IDELALISIB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Refractory follicular B-cell non-Hodgkin's lymphoma

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be refractory to a prior therapy with rituximab, **AND**
- The condition must be refractory to a prior therapy with an alkylating agent, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

The condition is considered refractory to a prior therapy when the patient experiences less than a partial response or progression of disease within 6 months after completion of the prior therapy.

The condition is considered refractory to both rituximab and an alkylating agent if the agents were administered together or in successive treatment regimens.

The authority application must be made in writing and must include:

a) A completed authority prescription form; and

b) A completed Refractory follicular B-cell non-Hodgkin's lymphoma PBS Authority Application - Supporting information form which must include date of completion of prior therapies with rituximab and an alkylating agent.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Refractory follicular B-cell non-Hodgkin's lymphoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition, **AND**
- Patient must not develop disease progression while receiving PBS-subsidised treatment with this drug for this condition.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

idelalisib 100 mg tablet, 60

11171Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5367.27	39.50	Zydelig [GI]

idelalisib 150 mg tablet, 60

11165P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	5367.27	39.50	Zydelig [GI]

▪ OLAPARIB

Note Special Pricing Arrangements apply.

Authority required

High grade serous ovarian cancer

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be platinum sensitive, **AND**
- Patient must have received at least two previous platinum-containing regimens, **AND**
- Patient must have relapsed following a previous platinum-containing regimen, **AND**
- Patient must be in partial or complete response to the immediately preceding platinum-based chemotherapy regimen, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have previously received PBS-subsidised treatment with this drug for this condition.

Population criteria:

- Patient must have evidence of a germline class 4 or 5 BRCA1 or BRCA2 gene mutation.

Platinum sensitivity is defined as disease progression greater than 6 months after completion of the penultimate platinum regimen.

A response (complete or partial) to the platinum-based chemotherapy regimen is to be assessed using either Gynaecologic Cancer InterGroup (GCIG) or Response Evaluation Criteria in Solid Tumours (RECIST) guidelines.

Evidence of a BRCA1 or BRCA2 gene mutation must be derived through germline testing.

Authority required

High grade serous fallopian tube cancer

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be platinum sensitive, **AND**
- Patient must have received at least two previous platinum-containing regimens, **AND**
- Patient must have relapsed following a previous platinum-containing regimen, **AND**
- Patient must be in partial or complete response to the immediately preceding platinum-based chemotherapy regimen, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have previously received PBS-subsidised treatment with this drug for this condition.

Population criteria:

- Patient must have evidence of a germline class 4 or 5 BRCA1 or BRCA2 gene mutation.

Platinum sensitivity is defined as disease progression greater than 6 months after completion of the penultimate platinum regimen.

A response (complete or partial) to the platinum-based chemotherapy regimen is to be assessed using either Gynaecologic Cancer InterGroup (GCIG) or Response Evaluation Criteria in Solid Tumours (RECIST) guidelines.

Evidence of a BRCA1 or BRCA2 gene mutation must be derived through germline testing.

Authority required

High grade serous primary peritoneal cancer

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be platinum sensitive, **AND**
- Patient must have received at least two previous platinum-containing regimens, **AND**
- Patient must have relapsed following a previous platinum-containing regimen, **AND**
- Patient must be in partial or complete response to the immediately preceding platinum-based chemotherapy regimen, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have previously received PBS-subsidised treatment with this drug for this condition.

Population criteria:

- Patient must have evidence of a germline class 4 or 5 BRCA1 or BRCA2 gene mutation.

Platinum sensitivity is defined as disease progression greater than 6 months after completion of the penultimate platinum regimen.

A response (complete or partial) to the platinum-based chemotherapy regimen is to be assessed using either Gynaecologic Cancer InterGroup (GCIG) or Response Evaluation Criteria in Solid Tumours (RECIST) guidelines.

Evidence of a BRCA1 or BRCA2 gene mutation must be derived through germline testing.

olaparib 50 mg capsule, 4 x 112

11034R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	6959.52	39.50	Lynparza [AP]

▪ OLAPARIB

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6715

High grade serous ovarian cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have progressive disease.

Authority required (STREAMLINED)

6705

High grade serous fallopian tube cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have progressive disease.

Authority required (STREAMLINED)

6716

High grade serous primary peritoneal cancer

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be maintenance therapy, **AND**
- Patient must not have progressive disease.

olaparib 50 mg capsule, 4 x 112

11050N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	6959.52	39.50	Lynparza [AP]

▪ VISMODEGIB

Caution Vismodegib is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 9 months and 2 months period after cessation of treatment for female and male patients respectively, as according to the TGA approved Product Information.

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

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

Note Special Pricing Arrangements apply.

Authority required

Metastatic or locally advanced basal cell carcinoma

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be inappropriate for surgery, **AND**
- The condition must be inappropriate for curative radiotherapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

The authority application must be made in writing and must include:

a) A completed authority prescription form; and

b) a completed Basal Cell Carcinoma Initial PBS Authority Application Form - Supporting Information Form; and

c) A histological confirmation of BCC and whether the condition is metastatic or locally advanced; and

d) A letter from a surgically qualified clinician demonstrating inappropriateness for surgery for patients with locally advanced BCC; and

e) A letter from a radiation oncologist demonstrating inappropriateness for curative radiotherapy for patients with locally advanced BCC; and

f) A signed patient acknowledgement.

The assessment of the patient's response to this PBS-subsidised course of therapy must be made within the 4 weeks prior to completion of the course of treatment. It is recommended that an application is submitted to the Department of Human Services no less than 2 weeks prior to the date the next dose is due in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Inappropriate for surgery is defined as:

i/ Curative resection is unlikely, such as where BCC has recurred in the same location after two or more surgical procedures; or

ii/ Anticipated substantial morbidity or deformity from surgery or requiring complicated reconstructive surgery (e.g. removal of all or part of a facial structure, such as nose, ear, eyelid, eye; or requirement for limb amputation or free tissue transfer); or

iii/ Medical contraindication to surgery

Inappropriate for curative radiotherapy is defined as:

i/Hypersensitivity to radiation due to genetic syndrome such as Gorlin Syndrome; or

ii/ Limitations due to location of tumour; or

iii/ Limitations due to cumulative prior radiotherapy dose; or

iv/ Progressive disease despite prior irradiation of locally advanced BCC.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Metastatic or locally advanced basal cell carcinoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received an authority prescription for this condition with this drug, **AND**
- The condition must not have progressed, **AND**
- The condition must remain inappropriate for surgery, **AND**
- The condition must remain inappropriate for curative radiotherapy, **AND**
- Patient must not receive more than 16 weeks of treatment per continuing treatment under this restriction.

The authority application must be made in writing and must include:

a) A completed authority prescription form; and

b) A completed Basal Cell Carcinoma Continuing PBS Authority Application Form - Supporting Information Form; and

c) A confirmation statement from the treating doctor that the disease has not progressed; and

d) In patients with locally advanced BCC, a letter from a surgically qualified clinician demonstrating that the condition remains inappropriate for surgery; or a letter from a radiation oncologist demonstrating that the condition remains inappropriate for curative radiotherapy.

The assessment of the patient's response to this PBS-subsidised course of therapy must be made within the 4 weeks prior to completion of the course of treatment. It is recommended that an application is submitted to the Department of Human Services no less than 2 weeks prior to the date the next dose is due in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Inappropriate for surgery is defined as:

i/ Curative resection is unlikely, such as where BCC has recurred in the same location after two or more surgical procedures; or

ii/ Anticipated substantial morbidity or deformity from surgery or requiring complicated reconstructive surgery (e.g. removal of all or part of a facial structure, such as nose, ear, eyelid, eye; or requirement for limb amputation or free tissue transfer); or

iii/ Medical contraindication to surgery

Inappropriate for curative radiotherapy is defined as:

i/Hypersensitivity to radiation due to genetic syndrome such as Gorlin Syndrome; or

ii/ Limitations due to location of tumour; or

iii/ Limitations due to cumulative prior radiotherapy dose; or

iv/ Progressive disease despite prior irradiation of locally advanced BCC.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Metastatic or locally advanced basal cell carcinoma

Treatment Phase: Initial treatment or Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete maximum of 16 weeks of treatment; OR

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete maximum of 16 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

vismodegib 150 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11070P	1	3	..	7449.52	39.50	Erivedge [RO]

▪ VORINOSTAT

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

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

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

Authority required

Cutaneous T-cell lymphoma

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have received systemic treatment with chemotherapy, **AND**
- Patient must demonstrate relapsed or chemotherapy-refractory disease, **AND**
- Patient must be ineligible for stem cell transplant, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed cutaneous T-cell lymphoma (CTCL) initial PBS Authority Application - Supporting Information Form.

vorinostat 100 mg capsule, 120

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11138F	1	2	..	4451.64	39.50	Zolinza [MK]

▪ VORINOSTAT

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

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

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

Authority required

Cutaneous T-cell lymphoma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease while receiving PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

vorinostat 100 mg capsule, 120

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11141J	1	1	..	4451.64	39.50	Zolinza [MK]

▪ ENDOCRINE THERAPY

HORMONES AND RELATED AGENTS

Progestogens

▪ MEDROXYPROGESTERONE

Restricted benefit

Advanced breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

medroxyprogesterone acetate 500 mg tablet, 30

2728N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	136.20	39.50	Provera [PF]

▪ MEDROXYPROGESTERONE

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

Restricted benefit

Endometrial cancer

medroxyprogesterone acetate 100 mg tablet, 100

2725K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	98.72	39.50	Provera [PF]

medroxyprogesterone acetate 250 mg tablet, 60

2727M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	136.20	39.50	Provera [PF]

medroxyprogesterone acetate 200 mg tablet, 60

2316X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	110.78	39.50	Provera [PF]

Gonadotropin releasing hormone analogues

▪ GOSERELIN

Restricted benefit

Carcinoma of the prostate

Clinical criteria:

- The condition must be locally advanced (stage C); OR
- The condition must be metastatic (stage D).

goserelin 10.8 mg implant, 1

8093Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1050.60	39.50	Zoladex 10.8 Implant [AP]

▪ GOSERELIN

Restricted benefit

Carcinoma of the prostate

Clinical criteria:

- The condition must be locally advanced (stage C); OR
- The condition must be metastatic (stage D).

Restricted benefit

Endometriosis

Clinical criteria:

- The condition must be visually proven, **AND**
- The treatment must be for the short-term (up to 6 months).

Note Only 1 course of not more than 6 months' therapy will be authorised.

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

Restricted benefit

Anticipated premature ovarian failure

Clinical criteria:

- Patient must be receiving treatment with an alkylating agent for a malignancy or an autoimmune disorder that has a high risk of causing premature ovarian failure, **AND**
- Patient must not receive more than 6 months' of treatment for this condition in a lifetime.

Population criteria:

- Patient must be pre-menopausal.

goserelin 3.6 mg implant, 1

1454M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	308.20	39.50	Zoladex Implant [AP]

▪ GOSERELIN (&) BICALUTAMIDE

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

Restricted benefit

Carcinoma of the prostate

Clinical criteria:

- The condition must be metastatic (stage D), **AND**
- Patient must require a combination of an antiandrogen and a GnRH (LH-RH) agonist.

goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [84 tablets], 1 pack

9066E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	1467.19	39.50	ZolaCos CP 10.8/50(84) [AP]

goserelin 3.6 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack

9064C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	457.51	39.50	ZolaCos CP 3.6/50 [AP]

goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack

9065D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	1189.46	39.50	ZolaCos CP 10.8/50(28) [AP]

▪ LEUPRORELIN

Restricted benefit

Central precocious puberty

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a paediatric endocrinologist; OR
- Must be treated by a medical practitioner in consultation with an endocrinologist specialising in paediatrics.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition.

leuprorelin acetate 30 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

10255R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1374.48	39.50	Lucrin Depot Paediatric 30 mg PDS [VE]

▪ LEUPRORELIN

Restricted benefit

Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate

leuprorelin acetate 7.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8707G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	393.95	39.50	Eligard 1 month [TL]

leuprorelin acetate 22.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8708H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1050.60	39.50	Eligard 3 month [TL]

leuprorelin acetate 30 mg injection: modified release [1] (&) inert substance diluent [2 mL syringe], 1 pack

8877F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1374.48	39.50	Lucrin Depot 4 Month PDS [VE]

leuprorelin acetate 30 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8709J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1374.48	39.50	Eligard 4 month [TL]

leuprorelin acetate 45 mg injection: modified release [1] (&) inert substance diluent [1 syringe], 1 pack

10656W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	2021.67	39.50	Lucrin Depot 6-Month [VE]

leuprorelin acetate 45 mg injection: modified release [1] (&) inert substance diluent [1 syringe], 1 pack

8859G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	2021.67	39.50	Eligard 6 month [TL]

leuprorelin acetate 7.5 mg injection: modified release [1] (&) inert substance diluent [2 mL syringe], 1 pack

8875D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	393.95	39.50	Lucrin Depot 7.5mg PDS [VE]

leuprorelin acetate 22.5 mg injection: modified release [1] (&) inert substance diluent [2 mL syringe], 1 pack

8876E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	1050.60	39.50	Lucrin Depot 3 Month PDS [VE]

▪ LEUPRORELIN

Restricted benefit

Central precocious puberty

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a paediatric endocrinologist; OR
- Must be treated by an endocrinologist specialising in paediatrics.

Population criteria:

- Patient must be aged 10 years or younger (girls) or 11 years or younger (boys), **AND**
- Patient must have had onset of signs or symptoms of central precocious puberty prior to the age of 8 years (girls) or 9 years (boys).

Restricted benefit

Central precocious puberty

Treatment Phase: Initial - grandfather

Clinical criteria:

- Patient must have received treatment with a gonadotropin releasing hormone analogue (GnRHa) for this condition prior to 1 May 2015.

Treatment criteria:

- Must be treated by a paediatric endocrinologist; OR
- Must be treated by an endocrinologist specialising in paediatrics.

leuprorelin acetate 30 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

10256T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	1374.48	39.50	Lucrin Depot Paediatric 30 mg PDS [VE]

▪ LEUPRORELIN (&) INERT SUBSTANCE (&) BICALUTAMIDE

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

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

Restricted benefit

Carcinoma of the prostate

Clinical criteria:

- The condition must be metastatic (stage D), **AND**
- Patient must require a combination of an antiandrogen and a GnRH (LH-RH) agonist.

leuprorelin acetate 22.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [28], 1 pack

10963B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	..	..	1123.38	39.50	Bi ELIGARD CP [TL]

leuprorelin acetate 22.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [84], 1 pack

10969H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	1268.94	39.50	Bi ELIGARD CP [TL]

leuprorelin acetate 7.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [28], 1 pack

10962Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	472.21	39.50	Bi ELIGARD CP [TL]

▪ TRIPTORELIN

Restricted benefit

Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate

triptorelin 3.75 mg injection [1 vial] (&) inert substance diluent [2 mL ampoule], 1 pack

9378N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	393.95	39.50	Diphereline [IS]

triptorelin 11.25 mg injection [1 vial] (&) inert substance diluent [2 mL ampoule], 1 pack

9379P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	1050.60	39.50	Diphereline [IS]

triptorelin 22.5 mg injection [1 vial] (&) inert substance diluent [2 mL ampoule], 1 pack

5297T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	2021.67	39.50	Diphereline [IS]

HORMONE ANTAGONISTS AND RELATED AGENTS

Anti-estrogens

▪ TAMOXIFEN

Note This pharmaceutical benefit is not PBS-subsidised for primary prevention of breast cancer.

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

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

tamoxifen 10 mg tablet, 60

2109B NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	20.05	21.26	Genox 10 [AF]

▪ TAMOXIFEN

Note For item codes 2110C and 1880Y, pharmaceutical benefits that have the form tablet 20 mg (base) are equivalent for the purposes of substitution.

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

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

tamoxifen 20 mg tablet, 30

1880Y NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*26.61	27.82	[a] Nolvadex-D [AP]

▪ TAMOXIFEN

Note This pharmaceutical benefit is not PBS-subsidised for primary prevention of breast cancer.

Note For item codes 2110C and 1880Y, pharmaceutical benefits that have the form tablet 20 mg (base) are equivalent for the purposes of substitution.

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

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

tamoxifen 20 mg tablet, 60

2110C NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	26.62	27.83	[a] Genox 20 [AF]	[a] GenRx Tamoxifen [GX]
					[a] Tamosin [QA]	[a] Tamoxifen Sandoz [SZ]

▪ TAMOXIFEN

Note A moderate risk of developing breast cancer is if the lifetime breast cancer risk is 1.5 to 3 times the population average. A high risk of developing breast cancer is if the lifetime breast cancer risk is more than 3 times the population average.

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

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

Restricted benefit
Reduction of breast cancer risk
Clinical criteria:

- Patient must have a moderate or high risk of developing breast cancer, **AND**
- The treatment must not exceed a dose of 20 mg per day, **AND**
- The treatment must not exceed a lifetime maximum of 5 years for this condition.

tamoxifen 20 mg tablet, 30

10911G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.85	20.06	[a] Genox 20 [AF]	[a] Nolvadex-D [AP]

▪ TOREMIFENE

toremifene 60 mg tablet, 30

8216K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	69.23	39.50	Fareston [AS]

Anti-androgens

▪ BICALUTAMIDE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5729
Metastatic (stage D) carcinoma of the prostate
Clinical criteria:

- The treatment must be in combination with GnRH (LH-RH) analogue therapy.

bicalutamide 50 mg tablet, 28

8094B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	56.89	39.50	[a] APO-Bicalutamide [TX] [a] Bicalox [ER] [a] Calutex [QA] [a] Cosudex [AP]	[a] Bicalide [JU] [a] Bicalutamide AN [EA] [a] Cosamide 50 [AF]

▪ CYPROTERONE

cyproterone acetate 100 mg tablet, 50

8019C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	66.87	39.50	[a] ANTERONE 100 [RW] [a] Cyprone 100 [AF] [a] Cyproterone AN [EA] [a] GenRx Cyproterone Acetate [GX]	[a] Cyprocur 100 [QA] [a] Cyprostat-100 [SY] [a] Cyproterone Sandoz [HX]
			[B]1.41	68.28	39.50	[a] Androcur-100 [BN]	

cyproterone acetate 50 mg tablet, 50

1270W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*82.69	39.50	[a] ANTERONE 50 [RW] [a] Cyprone [AF] [a] Cyproterone AN [EA] [a] Cyrotone [ER]	[a] Cyprocur 50 [QA] [a] Cyprostat [SY] [a] Cyproterone Sandoz [HX] [a] GenRx Cyproterone Acetate [GX]
			[B]2.28	*84.97	39.50	[a] Androcur [BN]	

▪ ENZALUTAMIDE

Note Special Pricing Arrangements apply.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required
Castration resistant metastatic carcinoma of the prostate
Clinical criteria:

- The treatment must not be used in combination with chemotherapy, **AND**

- Patient must have failed treatment with docetaxel due to resistance or intolerance; OR
- Patient must be unsuitable for docetaxel treatment on the basis of predicted intolerance to docetaxel, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must not receive PBS-subsidised treatment with this drug if progressive disease develops while on this drug, **AND**
- Patient must not have received prior treatment with abiraterone; OR
- Patient must have developed intolerance to abiraterone of a severity necessitating permanent treatment withdrawal.

enzalutamide 40 mg capsule, 112

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10174L	1	2	..	3702.82	39.50	Xtandi [LL]

▪ FLUTAMIDE

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

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

Authority required (STREAMLINED)

6611

Metastatic (stage D) carcinoma of the prostate

Clinical criteria:

- The treatment must be in combination with GnRH (LH-RH) analogue therapy.

flutamide 250 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2742H NP	3	5	..	*154.30	39.50	Flutamide MYLAN [AF]

▪ FLUTAMIDE

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

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

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

Authority required (STREAMLINED)

5816

Metastatic (stage D) carcinoma of the prostate

Clinical criteria:

- The treatment must be in combination with GnRH (LH-RH) analogue therapy.

flutamide 250 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1417N NP	1	5	..	170.37	39.50	Flutamin [AF]

▪ LEUPRORELIN (&) INERT SUBSTANCE (&) BICALUTAMIDE

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

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

Restricted benefit

Carcinoma of the prostate

Clinical criteria:

- The condition must be metastatic (stage D), **AND**
- Patient must require a combination of an antiandrogen and a GnRH (LH-RH) agonist.

leuprorelin acetate 22.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [28], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10963B	‡1	..	..	1123.38	39.50	Bi ELIGARD CP [TL]

leuprorelin acetate 22.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [84], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10969H	‡1	1	..	1268.94	39.50	Bi ELIGARD CP [TL]

leuprorelin acetate 7.5 mg modified release injection [1 syringe] (&) inert substance diluent [1 syringe] (&) bicalutamide 50 mg tablet [28], 1 pack

10962Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	472.21	39.50	Bi ELIGARD CP [TL]

▪ NILUTAMIDE

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

Authority required (STREAMLINED)
5785
Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate
Clinical criteria:
- The treatment must be in combination with GnRH (LH-RH) analogue therapy.

Authority required (STREAMLINED)
5647
Locally advanced (stage C) or metastatic (stage D) carcinoma of the prostate
Clinical criteria:
- The treatment must be in conjunction with surgical orchidectomy.

nilutamide 150 mg tablet, 30

8131Y NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	213.38	39.50	Anandron [SW]

Aromatase inhibitors

▪ ANASTROZOLE

Note This drug is not PBS-subsidised for primary prevention of breast cancer.

Note This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer where the total duration of this drug (or any other aromatase inhibitor) treatment extends beyond 5 years.

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

Restricted benefit
Breast cancer
Clinical criteria:
- The condition must be hormone receptor positive.

anastrozole 1 mg tablet, 30

8179L NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	29.13	30.34	[a] Anastrol [QA]	[a] Anastrozole AN [EA]
					[a] Anastrozole FBM [FO]	[a] Anastrozole GH [GQ]
					[a] Anastrozole Sandoz [SZ]	[a] APO-Anastrozole [TX]
					[a] Arianna 1 [AF]	[a] Arimidex [AP]
					[a] Astzol [JU]	[a] Azastrole [ER]

▪ EXEMESTANE

Restricted benefit
Metastatic (Stage IV) breast cancer
Clinical criteria:
- The condition must be hormone receptor positive, **AND**
- The condition must be human epidermal growth factor receptor 2 (HER2) negative, **AND**
- Patient must be receiving PBS-subsidised everolimus concomitantly for this condition.

Population criteria:
- Patient must not be pre-menopausal.

exemestane 25 mg tablet, 30

10103R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	66.59	39.50	[a] APO-Exemestane [TX]	[a] Estamane [JU]
					[a] Exaccord [RA]	[a] Exemestane AN [EA]
					[a] Exemestane GH [GQ]	[a] Exemestane Sandoz [SZ]
		[B]4.00	70.59	39.50	[a] Aromasin [PF]	

▪ EXEMESTANE

Note This drug is not PBS-subsidised for primary prevention of breast cancer.

Note This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer extended beyond 5 years, i.e. a patient who has received 2 years of tamoxifen therapy may only receive 3 years of PBS-subsidised treatment with exemestane.

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

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

exemestane 25 mg tablet, 30

8506Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	66.59	39.50	[a] APO-Exemestane [TX]	[a] Estamane [JU]
						[a] Exaccord [RA]	[a] Exemestane AN [EA]
						[a] Exemestane GH [GQ]	[a] Exemestane Sandoz [SZ]
			[B]4.00	70.59	39.50	[a] Aromasin [PF]	

▪ LETROZOLE

Note This drug is not PBS-subsidised for primary prevention of breast cancer.

Note This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer where the total duration of this drug (or any other aromatase inhibitor) treatment extends beyond 5 years.

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

Restricted benefit

Breast cancer

Clinical criteria:

- The condition must be hormone receptor positive.

letrozole 2.5 mg tablet, 30

8245Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	30.88	32.09	[a] APO-Letrozole [TX]	[a] Chem mart Letrozole [CH]
						[a] Femara 2.5 mg [NV]	[a] Femolet [AF]
						[a] Fera [QA]	[a] Gynotril [ER]
						[a] Letroz [JU]	[a] Letrozole AN [EA]
						[a] Letrozole FBM [FO]	[a] Letrozole generichealth [GQ]
						[a] Letrozole RBX [RA]	[a] Letrozole Sandoz [SZ]
						[a] Pharmacor Letrozole 2.5 [CR]	[a] Terry White Chemists Letrozole [TW]

Other hormone antagonists and related agents

▪ ABIRATERONE

Note Special Pricing Arrangements apply.

Authority required

Castration resistant metastatic carcinoma of the prostate

Clinical criteria:

- The treatment must be used in combination with a corticosteroid, **AND**
- The treatment must not be used in combination with chemotherapy, **AND**
- Patient must have failed treatment with docetaxel due to resistance or intolerance; OR
- Patient must be unsuitable for docetaxel treatment on the basis of predicted intolerance to docetaxel, **AND**
- Patient must have a WHO performance status of 2 or less, **AND**
- Patient must not receive PBS-subsidised abiraterone if progressive disease develops while on abiraterone, **AND**
- Patient must not have received prior treatment with enzalutamide; OR
- Patient must have developed intolerance to enzalutamide of a severity necessitating permanent treatment withdrawal.

abiraterone acetate 250 mg tablet, 120

2698B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	3603.06	39.50	Zytiga [JC]

abiraterone acetate 500 mg tablet, 60

11206T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	3603.06	39.50	Zytiga [JC]

▪ DEGARELIX

Restricted benefit

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

degarelix 80 mg injection [1 vial] (&) inert substance diluent [1 syringe], 1 pack

2784M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	393.95	39.50	Firmagon 80mg [FP]

▪ DEGARELIX

Note No applications for increased maximum quantities and/or repeats will be authorised for the 120 mg powder for injection.

Restricted benefit

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

degarelix 120 mg injection [2 vials] (&) inert substance diluent [2 syringes], 1 pack

2785N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	..	..	412.15	39.50	Firmagon 120mg [FP]

▪ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Interferons

▪ INTERFERON ALFA-2A

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Myeloproliferative disease

Clinical criteria:

- Patient must have excessive thrombocytosis.

interferon alfa-2a 9 million units/0.5 mL injection, 0.5 mL syringe

8553E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5	4	..	*477.25	39.50	Roferon-A [RO]

▪ INTERFERON ALFA-2A

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Low grade non-Hodgkin's lymphoma

Clinical criteria:

- The condition must have clinical features suggestive of a poor prognosis, **AND**
- The treatment must be in combination with anthracycline-based chemotherapy.

interferon alfa-2a 3 million units/0.5 mL injection, 0.5 mL syringe

8181N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
15	5	..	*477.40	39.50	Roferon-A [RO]

interferon alfa-2a 9 million units/0.5 mL injection, 0.5 mL syringe

8184R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5	5	..	*477.25	39.50	Roferon-A [RO]

▪ INTERFERON ALFA-2A

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Hairy cell leukaemia

Authority required

Myeloproliferative disease

Clinical criteria:

- Patient must have excessive thrombocytosis.

interferon alfa-2a 3 million units/0.5 mL injection, 0.5 mL syringe

8180M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
15	4	..	*477.40	39.50	Roferon-A [RO]

▪ INTERFERON ALFA-2B

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Hairy cell leukaemia

interferon alfa-2b 18 million units/1.2 mL injection, 1.2 mL

8572E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	4	..	*571.66	39.50	Intron A Redipen [MK]

▪ INTERFERON ALFA-2B

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Multiple myeloma

Treatment Phase: Maintenance treatment

Clinical criteria:

- The condition must be in remission following chemotherapy.

Authority required

Low grade non-Hodgkin's lymphoma

Clinical criteria:

- The condition must have clinical features suggestive of a poor prognosis, **AND**
- The treatment must be in combination with anthracycline-based chemotherapy.

interferon alfa-2b 30 million units/1.2 mL injection, 1.2 mL

8476D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	5	..	*949.60	39.50	Intron A Redipen [MK]

interferon alfa-2b 18 million units/1.2 mL injection, 1.2 mL

8348J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	5	..	*571.66	39.50	Intron A Redipen [MK]

▪ INTERFERON BETA-1A

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4881

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)

6860

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

interferon beta-1a 44 microgram/0.5 mL (12 million units) injection, 12 x 0.5 mL syringes

8403G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	998.56	39.50	Rebif 44 [SG]

interferon beta-1a 6 million units (30 microgram)/0.5 mL injection, 4 x 0.5 mL syringes

8805K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	998.56	39.50	Avonex [BD]

INTERFERON BETA-1a Injection 44 micrograms (12,000,000 i.u.) in 0.5 mL single dose autoinjector, 12

8968B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	998.56	39.50	Rebif 44 [SG]

interferon beta-1a 132 microgram/1.5 mL (12 million units) injection, 4 x 1.5 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9332E	1	5	..	998.56	39.50	Rebif 44 [SG]

▪ INTERFERON BETA-1B

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4881

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)

6860

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

interferon beta-1b 8 million international units (250 microgram) injection [15 x 250 microgram vials] (&) inert substance diluent [15 x 1.2 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8101J	1	5	..	994.39	39.50	Betaferon [BN]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11037X NP	1	2	..	1404.79	39.50	Pegasys [RO]

▪ PEGINTERFERON BETA-1A

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4881

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10212L	1	4	..	1050.09	39.50	Plegridy [BD]

peginterferon beta-1a 63 microgram/0.5 mL injection [0.5 mL injection device] (&) peginterferon beta-1a 94 microgram/0.5 mL injection [0.5 mL injection device], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10218T	‡1	..	..	1050.09	39.50	Plegridy [BD]

▪ PEGINTERFERON BETA-1A

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
6860
Multiple sclerosis
Treatment Phase: Continuing treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10220X	1	5	..	1050.09	39.50	Plegridy [BD]

Other immunostimulants

▪ GLATIRAMER ACETATE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
4881
Multiple sclerosis
Treatment Phase: Initial treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)
6860
Multiple sclerosis
Treatment Phase: Continuing treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

glatiramer acetate 40 mg/mL injection, 12 x 1 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10416F	1	5	..	1035.03	39.50	Copaxone [TB]

glatiramer acetate 20 mg/mL injection, 28 x 1 mL syringes

8726G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1035.03	39.50	Copaxone [TB]

▪ MYCOBACTERIUM BOVIS (BACILLUS CALMETTE AND GUERIN (BCG)) TICE STRAIN

Restricted benefit

Primary and relapsing superficial urothelial carcinoma of the bladder

Mycobacterium bovis (Bacillus Calmette and Guerin (BCG)) Tice strain 500 million colony forming units injection, 3 vials

1131M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	524.75	39.50	OncoTICE [MK]

▪ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

▪ ABATACEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

abatacept 125 mg/mL injection, 4 x 1 mL syringes

11068M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	953.23	39.50	Orencia ClickJect [BQ]

abatacept 125 mg/mL injection, 4 x 1 mL syringes

1221G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	953.23	39.50	Orencia [BQ]

▪ ABATACEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs

at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription forms; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Initial treatment with an I.V. loading dose: Two completed authority prescriptions must be submitted with the initial application. One prescription must be for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription must be written for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats.

Initial treatment with no loading dose: One completed authority prescription must be submitted with the initial application. The prescription must be written with a maximum quantity of 4 and up to 3 repeats.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**

- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription forms; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with this drugt and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Initial treatment with an I.V. loading dose: Two completed authority prescriptions must be submitted with the initial application. One prescription must be for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription must be written for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats.

Initial treatment with no loading dose: One completed authority prescription must be submitted with the initial application. The prescription must be written with a maximum quantity of 4 and up to 3 repeats.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to

Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

abatacept 125 mg/mL injection, 4 x 1 mL syringes

11092T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	953.23	39.50	Orencia ClickJect [BQ]

abatacept 125 mg/mL injection, 4 x 1 mL syringes

1220F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	953.23	39.50	Orencia [BQ]

▪ EVEROLIMUS

Caution Careful monitoring of patients is mandatory.

everolimus 500 microgram tablet, 60

8841H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	512.87	39.50	Certican [NV]

everolimus 750 microgram tablet, 60

8842J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	3	..	*1494.83	39.50	Certican [NV]

everolimus 1 mg tablet, 60

9352F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	3	..	*1967.37	39.50	Certican [NV]

everolimus 250 microgram tablet, 60

8840G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	258.84	39.50	Certican [NV]

▪ FINGOLIMOD

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Multiple sclerosis
Treatment Phase: Initial treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required
Multiple sclerosis
Treatment Phase: Continuing treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

fingolimod 500 microgram capsule, 28

5262Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2207.81	39.50	Gilenya [NV]

▪ LEFLUNOMIDE

Caution Leflunomide is a category X drug and must not be given to pregnant women. Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Authority required (STREAMLINED)

5766

Severe active psoriatic arthritis

Clinical criteria:

- Patient must have previously received, and failed to achieve an adequate response to, one or more disease modifying anti-rheumatic drugs including methotrexate; OR
- Patient must be clinically inappropriate for treatment with one or more disease modifying anti-rheumatic drugs including methotrexate, **AND**
- The treatment must be initiated by a physician.

leflunomide 20 mg tablet, 30

5450W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	43.93	39.50	[a] Arabloc [AV] [a] Ataris 20 [AF] [a] Leflunomide Sandoz [SZ]	[a] Arava [SW] [a] Leflunomide APOTEX [GX]

leflunomide 10 mg tablet, 30

5449T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	32.65	33.86	[a] Arabloc [AV] [a] Ataris 10 [AF] [a] Leflunomide Sandoz [SZ]	[a] Arava [SW] [a] Leflunomide APOTEX [GX]

▪ LEFLUNOMIDE

Caution Leflunomide is a category X drug and must not be given to pregnant women. Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Authority required (STREAMLINED)

5681

Severe active rheumatoid arthritis

Clinical criteria:

- Patient must have previously received, and failed to achieve an adequate response to, one or more disease modifying anti-rheumatic drugs including methotrexate; OR
- Patient must be clinically inappropriate for treatment with one or more disease modifying anti-rheumatic drugs including methotrexate, **AND**
- The treatment must be initiated by a physician.

leflunomide 20 mg tablet, 30

8375T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	43.93	39.50	[a] Arabloc [AV] [a] Ataris 20 [AF] [a] Leflunomide APOTEX [GX] [a] Leflunomide Sandoz [SZ]	[a] Arava [SW] [a] Leflunomide AN [EA] [a] Leflunomide GH [GQ] [a] Lunava 20 [ZP]

leflunomide 10 mg tablet, 30

8374R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	32.65	33.86	[a] Arabloc [AV] [a] Ataris 10 [AF] [a] Leflunomide APOTEX [GX] [a] Leflunomide Sandoz [SZ]	[a] Arava [SW] [a] Leflunomide AN [EA] [a] Leflunomide GH [GQ] [a] Lunava 10 [ZP]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

mycophenolate 360 mg enteric tablet, 120

2193K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	195.71	39.50	Myfortic [NV]

mycophenolate mofetil 500 mg tablet, 50

8650G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	5	..	*152.89	39.50	[a] APO-Mycophenolate [TX] [a] Ceptolate [AF] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Mycophenolate AN [EA] [a] Pharmacor Mycophenolate 500 [CR]

mycophenolate mofetil 1 g/5 mL powder for oral liquid, 165 mL

8651H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	#279.62	39.50	CellCept [RO]

mycophenolate 180 mg enteric tablet, 120

2150E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	103.33	39.50	Myfortic [NV]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Note For item codes 8649F and 1836P, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

mycophenolate mofetil 250 mg capsule, 100

8649F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	5	..	*152.95	39.50	[a] APO-Mycophenolate [TX] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Pharmacor Mycophenolate 250 [CR]

mycophenolate Capsule 250 mg, 50

1836P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	6	5	..	*152.95	39.50	[a] Ceptolate [AF]

▪ SIROLIMUS

Caution Careful monitoring of patients is mandatory.

sirolimus 1 mg/mL oral liquid, 60 mL

8725F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	3	..	499.55	39.50	Rapamune [PF]

sirolimus 1 mg tablet, 100

8724E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	769.48	39.50	Rapamune [PF]

sirolimus 2 mg tablet, 100

8833X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1499.62	39.50	Rapamune [PF]

sirolimus 500 microgram tablet, 100

8984W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	387.15	39.50	Rapamune [PF]

▪ TERIFLUNOMIDE

Caution Teriflunomide is a category X drug and must not be given to pregnant women or women of childbearing potential who are not currently using reliable contraception.

Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

teriflunomide 14 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2898M	1	5	..	1837.26	39.50	Aubagio [GZ]

▪ TOFACITINIB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a

patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR

- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

tofacitinib 5 mg tablet, 56

10511F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1267.40	39.50	Xeljanz [PF]

▪ TOFACITINIB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of

treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 3 (Grandfather patients)

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have been receiving treatment with this drug for this condition prior to 1 October 2015, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(c) a signed patient acknowledgement.

All applications for treatment with this drug for this condition under this restriction must include baseline joint count and ESR and/or CRP as determined at the completion of a 6 month intensive DMARD trial but prior to ceasing DMARD therapy.

If the requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

tofacitinib 5 mg tablet, 56

10517M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1267.40	39.50	Xeljanz [PF]

Tumor necrosis factor alpha (TNF-) inhibitors

▪ ADALIMUMAB

Note Special Pricing Arrangements apply.

Note Authority approval for sufficient therapy to complete the balance of supply may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authority approval for sufficient therapy to complete the balance of supply should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with adalimumab for severe refractory Crohn disease and infliximab for moderate to severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time.

For paediatric patients with Crohn disease, infliximab is PBS-subsidised for moderate to severe disease while adalimumab is PBS-subsidised for severe disease.

From 1 August 2015, under the PBS, patients commencing on adalimumab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to infliximab. Patients on infliximab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist but will need to meet a PCDAI score of greater than or equal to 40 when swapping to adalimumab. Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2015 is considered to be in their first cycle as of 1 August 2015.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2015.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2015, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to theDepartment of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient with severe disease may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Crohn Disease Activity Index (PCDAI) Score, confirmation of Crohn

disease), or the prior conventional therapies of corticosteroid therapy, immunosuppressive therapy or enteral nutrition.
Patients on infliximab may swap to adalimumab within the same treatment cycle provided that their disease severity has progressed to severe disease (i.e. they have a current PCDAI score of 40 or more).
A patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PCDAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
Patients must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months immediately prior to the time the PCDAI score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply for paediatric patient

Clinical criteria:

- Patient must have received insufficient therapy with this drug under Initial 1 (new patient or patient recommencing treatment after break of more than 5 years) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) or Initial 3 (grandfathered patients) or Continuing treatment to complete the maximum duration of treatment specified in the relevant treatment phase, **AND**
- The treatment must provide no more than the balance of up to 16 weeks of therapy (new patients or change/re-commencement patients; Initial 1 or Initial 2) or 24 weeks of therapy (Continuing patients or Grandfathered patients).

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

10422M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

10400J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

10399H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Moderate to severe hidradenitis suppurativa

Treatment Phase: Initial treatment 1 - New patient or Initial treatment 2 - Recommencement of treatment – balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the Initial treatment 1 - New patient restriction to complete a maximum of 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial treatment 2 - Recommencement of treatment restriction to complete a maximum of 16 weeks treatment.

Treatment criteria:

- Must be treated by a dermatologist.

A maximum of 12 weeks of treatment will be authorised under this restriction.

adalimumab 40 mg/0.8 mL injection, 4 x 0.8 mL cartridges

11133Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	2709.24	39.50	Humira [VE]

▪ ADALIMUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**
- Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

5284D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

5283C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.
Written applications for authority to prescribe adalimumab should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Note TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.
From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.
A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Note No applications for increased maximum quantities and/or repeats will be authorised.

Authority required

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with adalimumab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and

(c) has not failed PBS-subsidised therapy with adalimumab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the time frames specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

8965W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

8961P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	3989.10	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8963R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

8962Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	3989.10	39.50	Humira [VE]

▪ ADALIMUMAB

Note Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Note TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is

reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Note No applications for increased maximum quantities and/or repeats will be authorised.

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with adalimumab.

Initial PBS-subsidised supply for continuing treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

(a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with adalimumab prior to 4 November 2010; and

(b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with adalimumab; and

(c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) is receiving treatment with adalimumab at the time of application; and

(e) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with adalimumab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

A maximum of 24 weeks treatment will be approved under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, an assessment of the patient's response must be made following a minimum of 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

8966X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8964T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Moderate to severe hidradenitis suppurativa

Treatment Phase: Initial treatment 1 - New patient

Clinical criteria:

- Patient must have, at the time of application, a Hurley stage II or III grading with an abscess and inflammatory nodule (AN) count greater than or equal to 3, **AND**
- Patient must have failed to achieve an adequate response to 2 courses of different antibiotics each for 3 months prior to initiation of PBS subsidised treatment with this drug for this condition; OR
- Patient must have had an adverse reaction to an antibiotic of a severity necessitating permanent treatment withdrawal resulting in the patient being unable to complete treatment with 2 different courses of antibiotics each for 3 months prior to initiation of PBS-subsidised treatment with this drug for this condition; OR
- Patient must be contraindicated to treatment with an antibiotic due to an allergic reaction of a severity necessitating permanent treatment withdrawal resulting in the patient being unable to complete treatment with 2 different courses of antibiotics each for 3 months prior to initiation of PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be limited to a maximum duration of 16 weeks.

Treatment criteria:

- Must be treated by a dermatologist.

Assessment of disease severity must be no more than 1 month old at the time of application.

An assessment of the patient's response to this recommencement course of treatment must be made following a minimum of 12 weeks of treatment.

At the time of authority application the prescriber must request the first 4 weeks of treatment under this restriction; and weeks 5 to 16 of treatment under Initial treatment 1 - New patient or Initial treatment 2 - Recommencement of treatment - balance of supply

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed hidradenitis suppurativa PBS authority application supporting Information form which must include:

(i) the Hurley stage grading; and

(ii) the AN count; and

(iii) the name of the antibiotic/s received for two separate courses each of three months; or

(iv) confirmation that the adverse reaction or allergy to an antibiotic necessitated permanent treatment withdrawal resulting in the patient being unable to complete a three month course of antibiotics. The name of the one course of antibiotics of three months duration must be provided. Where the patient is unable to be treated with any courses of antibiotics the prescriber must confirm that the patient has a history of adverse reaction or allergy necessitating permanent treatment withdrawal to two different antibiotics

(v) a signed patient acknowledgement.

Authority required

Moderate to severe hidradenitis suppurativa

Treatment Phase: Initial treatment 2 - Recommencement of treatment

Clinical criteria:

- Patient must have, at the time of application, a Hurley stage II or III grading with an abscess and inflammatory nodule (AN) count greater than or equal to 3, **AND**
- Patient must have demonstrated a response to the most recent PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be limited to a maximum duration of 16 weeks.

Treatment criteria:

- Must be treated by a dermatologist.

Assessment of disease severity must be no more than 1 month old at the time of application.

A response to treatment is defined as:

Achieving Hidradenitis Suppurativa Clinical Response (HiSCR) of a 50% reduction in AN count compared to baseline with no increase in abscesses or draining fistulae.

An assessment of the patient's response to this recommencement course of treatment must be made following a minimum of 12 weeks of treatment.

At the time of authority application the prescriber must request the first 4 weeks of treatment under this restriction; and weeks 5 to 16 of treatment under Initial treatment 1 - New patient or Initial treatment 2 - Recommencement of treatment - balance of supply

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed hidradenitis suppurativa PBS authority application supporting Information form which must include:

(i) the Hurley stage grading; and

(ii) the AN count.

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

11132X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	3989.10	39.50	Humira [VE]

▪ ADALIMUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Moderate to severe hidradenitis suppurativa

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a response to treatment with this drug for this condition.

Treatment criteria:

- Must be treated by a dermatologist.

A response to treatment is defined as:

Achieving Hidradenitis Suppurativa Clinical Response (HiSCR) of a 50% reduction in AN count compared to baseline with no increase in abscesses or draining fistulae.

For the first application for continuing treatment a Hidradenitis Suppurativa Clinical Response (HiSCR) assessment must be made following a minimum of 12 weeks of treatment. For subsequent continuing treatment a HiSCR assessment must be made every 24 weeks.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and provided to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

A maximum of 24 weeks treatment will be authorised under this restriction per continuing treatment.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed hidradenitis suppurativa PBS authority application supporting Information form which must include the Hidradenitis Suppurativa Clinical Response (HiSCR) result.

Authority required

Moderate to severe hidradenitis suppurativa

Treatment Phase: Initial treatment 3 - Grandfathered patient

Clinical criteria:

- Patient must have been receiving treatment with this drug for this condition prior to 1 July 2017, **AND**
- Patient must have had a Hurley stage II or III with an abscess and inflammatory nodule (AN) count greater than or equal to 3 prior to starting treatment with this drug, **AND**
- Patient must have demonstrated a response to treatment by achieving Hidradenitis Suppurativa Clinical Response (HiSCR) after 12 weeks of treatment if the patient has been treated with this drug for this condition for 12 weeks or longer, **AND**
- Patient must have failed to achieve an adequate response to 2 courses of different antibiotics each for 3 months prior to initiation of PBS subsidised treatment with this drug for this condition; OR
- Patient must have had an adverse reaction to an antibiotic of a severity necessitating permanent treatment withdrawal resulting in the patient being unable to complete treatment with 2 different courses of antibiotics each for 3 months prior to initiation of PBS-subsidised treatment with this drug for this condition; OR
- Patient must be contraindicated to treatment with an antibiotic due to an allergic reaction of a severity necessitating permanent treatment withdrawal resulting in the patient being unable to complete treatment with 2 different courses of antibiotics each for 3 months prior to initiation of PBS-subsidised treatment with this drug for this condition.

Treatment criteria:

- Must be treated by a dermatologist.

A response to treatment is defined as:

Achieving Hidradenitis Suppurativa Clinical Response (HiSCR) of a 50% reduction in AN count compared to baseline with no increase in abscesses or draining fistulae.

For the first application for continuing treatment a Hidradenitis Suppurativa Clinical Response (HiSCR) assessment must be made following a minimum of 12 weeks of treatment. For subsequent continuing treatment a HiSCR assessment must be made every 24 weeks.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and provided to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Assessment of disease severity must be no more than 1 month old at the time treatment with this drug was initiated.
A maximum of 24 weeks treatment will be authorised under this restriction.
A patient may qualify for PBS-subsidised treatment under this restriction once only.
For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the continuing treatment criteria or recommencement of treatment criteria where there is a break in treatment.
The authority application must be made in writing and must include:
(a) a completed authority prescription form; and
(b) completed hidradenitis suppurativa PBS authority application supporting Information form which must include:
(i) the Hurley stage grading; and
(ii) the AN count; and
(iii) the name of the antibiotic/s received for two separate courses each of three months; or
(iv) confirmation that the adverse reaction or allergy to an antibiotic necessitated permanent treatment withdrawal resulting in the patient being unable to complete a three month course of antibiotics. The name of the one course of antibiotics of three months duration must be provided. Where the patient is unable to be treated with any courses of antibiotics the prescriber must confirm that the patient has a history of adverse reaction or allergy necessitating permanent treatment withdrawal to two different antibiotics
(v) the Hidradenitis Suppurativa Clinical Response (HiSCR) result if the patient has received 12 weeks or more of treatment
(vi) a signed patient acknowledgement.

adalimumab 40 mg/0.8 mL injection, 4 x 0.8 mL cartridges

11137E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	2709.24	39.50	Humira [VE]

▪ ADALIMUMAB

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break

in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who

continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide sufficient dose. Up to a maximum of 5 repeats will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9191R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9189P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note Special Pricing Arrangements apply.

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH REFRACTORY CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with adalimumab for severe refractory Crohn disease and infliximab for moderate to severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time.
For paediatric patients with Crohn disease, infliximab is PBS-subsidised for moderate to severe disease while adalimumab is PBS-subsidised for severe disease.
From 1 August 2015, under the PBS, patients commencing on adalimumab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to infliximab. Patients on infliximab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist but will need to meet a PCDAI score of greater than or equal to 40 when swapping to adalimumab.
Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.
A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2015 is considered to be in their first cycle as of 1 August 2015.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2015.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.
From 1 August 2015, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to theDepartment of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient with severe disease may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Crohn Disease Activity Index (PCDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy, immunosuppressive therapy or enteral nutrition.
Patients on infliximab may swap to adalimumab within the same treatment cycle provided that their disease severity has progressed to severe disease (i.e. they have a current PCDAI score of 40 or more).
A patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PCDAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
Patients must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months immediately prior to the time the PCDAI score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new paediatric patient) of Crohn disease in a paediatric patient assessed by PCDAI (Initial 1)

Clinical criteria:

- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist, consultant physician, paediatrician or specialist paediatric gastroenterologist, **AND**
- Patient must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contra-indication to each of prednisolone (or equivalent), azathioprine, 6-mercaptopurine and methotrexate, **AND**
- Patient must have, at the time of application, disease severity considered to be severe as demonstrated by a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 40 preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment and which is no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Applications for authorisation of initial treatment must be in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of previous systemic drug therapy [dosage, date of commencement and duration of therapy] or dates of enteral nutrition; and

(iii) the signed patient or guardian acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application. If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Human Services website (www.humanservices.gov.au).

A maximum quantity and number of repeats to provide for an initial 16 week course of this drug consisting of a 160 mg dose at week 0, 80 mg dose at week 2 and 40 mg dose at weeks 4, 6, 8, 10, 12 and 14 for patients 40 kg or greater (for patients 40 kg or less, the course is a 80 mg dose at week 0, 40 mg dose at week 2 and a 20 mg dose at weeks 4, 6, 8, 10, 12 and 14) will be authorised.

Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater: one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg: one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

If fewer than 2 repeats (for patients 40 kg or greater) or 3 repeats (for patients less than 40 kg) are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these time-frames, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Change or re-commencement of treatment of Crohn disease in a paediatric patient assessed by PCDAI (Initial 2)

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with this drug for this condition; OR
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with infliximab for this condition and have a current PCDAI score of 40 or greater, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition more than once in the current treatment cycle.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Applications for authorisation of initial treatment must be in writing and must include:

(a) two completed authority prescription form; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) Score calculation sheet; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater: one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg: one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

If fewer than 2 repeats (for patients 40 kg or greater) or 3 repeats (for patients less than 40 kg) are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these time-frames, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

10389T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

10413C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

10404N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	3989.10	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

10419J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

10397F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	3989.10	39.50	Humira [VE]

▪ ADALIMUMAB

Note Special Pricing Arrangements apply.

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH REFRACTORY CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with adalimumab for severe refractory Crohn disease and infliximab for moderate to severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time.
For paediatric patients with Crohn disease, infliximab is PBS-subsidised for moderate to severe disease while adalimumab is PBS-subsidised for severe disease.
From 1 August 2015, under the PBS, patients commencing on adalimumab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to infliximab. Patients on infliximab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist but will need to meet a PCDAI score of greater than or equal to 40 when swapping to adalimumab.
Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2015 is considered to be in their first cycle as of 1 August 2015.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2015.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.
From 1 August 2015, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to theDepartment of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient with severe disease may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Crohn Disease Activity Index (PCDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy, immunosuppressive therapy or enteral nutrition.
Patients on infliximab may swap to adalimumab within the same treatment cycle provided that their disease severity has progressed to severe disease (i.e. they have a current PCDAI score of 40 or more).
A patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PCDAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
Patients must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months immediately prior to the time the PCDAI score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Severe Crohn disease

Treatment Phase: Initial PBS-subsidised treatment of Crohn disease in a paediatric patient who has previously received non-PBS-subsidised therapy with this drug (Initial 3 - Grandfather)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have been receiving treatment with this drug prior to 1 August 2015, **AND**
- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist, consultant physician, paediatrician or specialist paediatric gastroenterologist, **AND**
- Patient must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contra-indication to each of prednisolone (or equivalent), azathioprine, 6-mercaptopurine and methotrexate, **AND**
- Patient must have had disease severity considered to be severe as demonstrated by a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 40 preferably whilst still on prior conventional treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug as defined as a reduction in PCDAI Score by at least 15 points as compared to baseline and a total of PCDAI score of 40 points or less with the PCDAI assessment being no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current and baseline Paediatric Crohn Disease Activity Index (PCDAI) Score calculation sheet;

(ii) the date of commencement of this drug; and

(iii) the signed patient or guardian acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

The patient's current PCDAI assessment must be no more than 1 month old at the time of application. The baseline PCDAI assessment must be from immediately prior to commencing treatment with this drug.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

A maximum of 24 weeks treatment will be approved under this criterion.

Where fewer than 5 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment with this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction.

Patients may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment of Crohn disease in a paediatric patient assessed by PCDAI

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug as defined as a reduction in PCDAI Score by at least 15 points as compared to baseline and a total of PCDAI score of 40 points or less with the PCDAI assessment being no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition.

The PCDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, a PCDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction.

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

10396E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

10420K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

10412B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR
- Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a

treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to

therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

5282B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

5281Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing)

with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9104E	1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9078T	1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient

will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**

- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Applications for treatment with this drug where the dosing frequency exceeds 40 mg per fortnight will not be approved.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9100Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8741C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or

(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and

(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant

restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9102C	1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9034L	1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .
(a) Initial treatment. Applications for initial treatment should be made where:
(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).
Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.
A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks

providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab, vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.
For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Note TREATMENT OF PAEDIATRIC PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with infliximab or adalimumab for moderate to severe ulcerative colitis; and infliximab for acute severe ulcerative colitis. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to infliximab and adalimumab only.A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time. Infliximab and adalimumab are PBS-subsidised for moderate to severe disease while only infliximab is PBS-subsidised for acute severe disease.From 1 June 2017, under the PBS, all will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent.Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 June 2017 is considered to be in their first cycle as of 1 June 2017. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle. A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle. There is no limit to the number of treatment cycles a patient may undertake in their lifetime.(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 June 2017.(a) Initial treatment.Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or (ii) a patient has received prior PBS-subsidised (initial or continuing) treatment with a TNF-alfa antagonist and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping treatment' below]; or (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2). Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of treatment for adalimumab and 14 weeks of treatment for infliximab. From 1 June 2017, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for

infliximab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted tothe Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply. Assessments of response to a course of PBS-subsidised treatment must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.(2) Swapping treatment. Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Ulcerative Colitis Activity Index (PUCAI) Score, confirmation of ulcerative colitis disease), or the prior conventional therapies of corticosteroids or immunosuppressives.A patient may trial an alternate agent at any time, regardless of whether they are receiving treatment (initial or continuing) with infliximab or adalimumab at the time of the application. However, a patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PUCAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the PUCAI score is measured.(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab. A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 June 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction. 'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient or Recommencement of treatment after more than 5 years break in therapy - Initial 1)

Clinical criteria:

- Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**
- Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg (for a child, 1 to 2 mg/kg up to 40 mg) prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, and followed by a failure to achieve an adequate response to 3 or more months of treatment of an appropriately dosed thiopurine agent, **AND**
- Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR
- Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score); OR
- Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Applications for authorisation of initial treatment must be in writing and must include:(a) two completed authority prescription forms; and(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and(iii) the signed patient acknowledgement or guardian acknowledgement.

For patients weighing 40 kg or greater, a maximum quantity and number of repeats to provide for an initial 16 weeks course of this drug consisting of a 160 mg dose at week 0, 80 mg dose at week 2 and 40 mg dose at weeks 4, 6, 8, 10, 12 and 14 will be authorised.

For patients weighing less than 40 kg, a maximum quantity and number of repeats to provide for an initial 16 weeks of this drug consisting of a 80 mg dose at week 0, 40 mg dose at week 2 and a 20 mg dose at weeks 4, 6, 8, 10, 12 and 14 will be authorised.

Two completed authority prescriptions must be submitted with every initial application for this drug.For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription must be written for 2 doses of 40 mg and 2 repeats.

For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment.

The most recent Mayo clinic, partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) score must be no more than 1 month old at the time of application.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 within the first 12 weeks of receiving this drug for ulcerative colitis, or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The patient or guardian (required if patient is aged 6 to 17 years) must have signed a patient acknowledgement indicating that he or she understands and acknowledges that the PBS-subsidised treatment will cease if he or she does not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Note At the time of the authority application, medical practitioners should request sufficient quantity for up to 16 weeks of treatment under this restriction.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Change or Re-commencement of treatment after a break of less than 5 years in therapy (Initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with adalimumab, infliximab or vedolizumab for this condition in this treatment cycle; OR

- Patient must have previously received PBS-subsidised treatment with adalimumab or infliximab for this condition in this treatment cycle if aged 6 to 17 years, **AND**
- Patient must not have failed PBS-subsidised treatment with adalimumab for this condition in the current treatment cycle; OR
- Patient must not have failed PBS-subsidised treatment with adalimumab for this condition in the current treatment cycle more than once if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of this drug within the timelines specified in the relevant restriction. If the response assessment to the previous course of this drug is not submitted as detailed in the relevant restriction, the patient will be deemed to have failed therapy with this drug.

Applications for authorisation of initial treatment must be in writing and must include:

(a) two completed authority prescription forms; and(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy].

Two completed authority prescriptions must be submitted with every initial application for this drug.For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription must be written for 2 doses of 40 mg and 2 repeats.

For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

Note At the time of the authority application, medical practitioners should request sufficient quantity for up to 16 weeks of treatment under this restriction.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply for Initial 1 and Initial 2

Clinical criteria:

- Patient must have received insufficient treatment with this drug under the Initial 1 (new patient or recommencement of treatment after more than 5 years break in therapy) restriction to complete 16 weeks of treatment; OR
- Patient must have received insufficient treatment with this drug under the Initial 2 (Change or Re-commencing of treatment after less than 5 years break in therapy) to complete 16 weeks of treatment.

Population criteria:

- Patient must be 6 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services.

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

11127P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

10955N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

10972L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	3989.10	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

10944B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

10945C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	3989.10	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle. A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .

(a) Initial treatment. Applications for initial treatment should be made where:

(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).

Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.

A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab, vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of

disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.
For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Note TREATMENT OF PAEDIATRIC PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with infliximab or adalimumab for moderate to severe ulcerative colitis; and infliximab for acute severe ulcerative colitis. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to infliximab and adalimumab only.A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time. Infliximab and adalimumab are PBS-subsidised for moderate to severe disease while only infliximab is PBS-subsidised for acute severe disease.From 1 June 2017, under the PBS, all will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent.Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 June 2017 is considered to be in their first cycle as of 1 June 2017. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle. A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle. There is no limit to the number of treatment cycles a patient may undertake in their lifetime.(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 June 2017.(a) Initial treatment.Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or (ii) a patient has received prior PBS-subsidised (initial or continuing) treatment with a TNF-alfa antagonist and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping treatment' below]; or (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2). Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of treatment for adalimumab and 14 weeks of treatment for infliximab. From 1 June 2017, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted tothe Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply. Assessments of response to a course of PBS-subsidised treatment must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.(2) Swapping treatment. Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Ulcerative Colitis Activity Index (PUCAI) Score, confirmation of ulcerative colitis disease), or the prior conventional therapies of corticosteroids or immunosuppressives.A patient may trial an alternate agent at any time, regardless of whether they are receiving treatment (initial or continuing) with infliximab or adalimumab at the time of the application. However, a patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.To avoid confusion, an application

for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PUCAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the PUCAI score is measured.(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab. A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 June 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction. 'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR
- Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Patients who have failed to maintain a partial Mayo clinic score of less than or equal to 2, with no subscore greater than 1, or, patients who have failed to maintain a Paediatric Ulcerative Colitis Activity Index (PUCAI) score of less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

At the time of the authority application, medical practitioners should request sufficient quantity for up to 24 weeks of treatment under this restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No applications for increased repeats will be authorised.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial 3 (Grandfathered patient)

Clinical criteria:

- Patient must have a documented history of moderate to severe ulcerative colitis, **AND**

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 December 2016, **AND**
- Patient must be receiving treatment with this drug at the time of application, **AND**
- Patient must have a Mayo score greater than or equal to 6 prior to commencing treatment with this drug; OR
- Patient must have a partial Mayo score is greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo score) prior to commencing treatment with this drug; OR
- Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 prior to commencing treatment with this drug, if aged 6 to 17 years; OR
- Patient must have a documented history of moderate to severe refractory ulcerative colitis prior to having commenced treatment with this drug where a Mayo clinic, partial Mayo clinic or PUCAI baseline assessment is not available, if aged 6 to 17 years, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR
- Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Applications for authorisation of initial treatment must be in writing and must include: (a) a completed authority prescription form; and (b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following: (i) the completed current and baseline Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheets including the dates of assessment of the patient's condition; and (ii) the date of commencement of this drug; and (iii) the signed patient or guardian acknowledgement

The current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) assessment must be no more than 1 month old at the time of application. The baseline assessment must be from immediately prior to commencing treatment with this drug. Where a baseline assessment is not available the prescriber must contact the Department of Human Services to discuss.

At the time of the authority application, medical practitioners should request sufficient quantity for up to 24 weeks of treatment under this restriction.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note The patient or guardian (required if patient is aged 6 to 17 years) must have signed a patient acknowledgement indicating that he or she understands and acknowledges that the PBS-subsidised treatment will cease if he or she does not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply for Continuing treatment and Initial 3 (Grandfathered patients)

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR
- Patient must have received insufficient treatment with this drug to complete 24 weeks of treatment under the Initial 3 (Grandfathered patients).

Population criteria:

- Patient must be 6 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services.

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

11121H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

10961X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

10960W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing

they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Applications for treatment with this drug where the dosing frequency exceeds 40 mg per fortnight will not be approved.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Applications for treatment with this drug where the dosing frequency exceeds 40 mg per fortnight will not be approved.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9099X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8737W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5

years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

---

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

- Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9103D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9077R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).

Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.

From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.

A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.

From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.

For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure

uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Note No applications for increased maximum quantities will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting the Department of Human Services.

Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity and number of repeats to provide for an initial 16 week course of this drug will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity and number of repeats to provide for an initial 16 week course of this drug will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the initial dose (i.e. the initial infusion regimen at weeks 0 and 2); OR

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 2 doses (new patients) or 5 repeats (Continuing treatment).

Population criteria:

- Patient must be aged 18 years or older.

Authority approval for sufficient therapy to complete a maximum of 2 initial doses or 5 repeats may be requested by telephone by contacting the Department of Human Services

Note No increase in the maximum quantity or number of units may be authorised.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9190Q	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9186L	1	..	..	3989.10	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9188N	1	2	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9187M	1	..	..	3989.10	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9101B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9033K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability

arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority

application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9428F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9427E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1401.83	39.50	Humira [VE]

▪ ADALIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial

3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9426D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	4	..	1401.83	39.50	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9425C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	4	..	1401.83	39.50	Humira [VE]

▪ CERTOLIZUMAB PEGOL

Note Authority approval for sufficient therapy to complete a maximum of 18-20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 18-20 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 18 to 20 weeks treatment, depending on the dosage regimen; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 18 to 20 weeks treatment, depending on the dosage regimen, **AND**
- The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10892G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient

will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

- Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 to 20 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 to 20 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10897M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing)

with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

3425G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have not failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times., **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction..

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction..

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10905Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	..	..	*3549.97	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or

(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note Authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 18 to 20 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 18 to 20 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10896L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years

may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:
(a) a completed authority prescription form; and
(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.
All measurements provided must be no more than 1 month old at the time of application.
A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.
All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.
Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis
Treatment Phase: Continuing treatment – balance of supply
Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10137M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 to 20 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

---

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 to 20 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10904X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	..	..	*3549.97	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10238W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1202.08	39.50	Cimzia [UC]

▪ CERTOLIZUMAB PEGOL

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab,

etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10909E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	..	..	*3549.97	39.50	Cimzia [UC]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab,

etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

7217

Severe psoriatic arthritis

Treatment Phase: Subsequent continuing treatment

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised biological agent treatment for this condition in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments.

The measurement of response to the prior course of therapy must be documented in the patient's medical notes.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was issued in this cycle and the date of the first application under a new cycle.

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11216H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11202N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose

for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

7276

Severe active rheumatoid arthritis

Treatment Phase: Subsequent continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**

- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The measurement of response to the prior course of therapy must be documented in the patient's medical notes.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11211C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11218K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.

Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an

alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

7168

Active ankylosing spondylitis

Treatment Phase: Subsequent continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist.

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

The measurement of response to the prior course of therapy must be documented in the patient's medical notes.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was issued in this cycle and the date of the first application under a new cycle.

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11217J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11215G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is

they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.

Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

7317

Severe chronic plaque psoriasis

Treatment Phase: Subsequent continuing treatment, whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

The measurement of response to the prior course of therapy must be documented in the patient's medical notes.

Determination of response must be based on the PASI assessment of response to the most recent course of treatment with this drug.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required (STREAMLINED)

7296

Severe chronic plaque psoriasis

Treatment Phase: Subsequent continuing treatment, face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

The measurement of response to the prior course of therapy must be documented in the patient's medical notes.

Determination of response must be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11225T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11221N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Brenzys [MK]

▪ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have demonstrated an adequate response to treatment with etanercept, **AND**
- Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the

approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

3449M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

3450N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

3448L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks

of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Subsequent continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist.

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be 18 years or older.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Each application for continuing treatment with this drug must include a measurement of response to the prior course of therapy. If the response assessment is not submitted, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was issued in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Active ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11196G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11201M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

11204Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new

Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Subsequent continuing treatment

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised biological agent treatment for this condition in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR

- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments.

Each application for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. Where a response assessment is not submitted the patient will be deemed to have failed to respond to treatment with this drug.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11208X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11198J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

11207W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient

has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Subsequent continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:(1) a completed authority prescription form; and(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for subsequent continuing treatment with this product must include a measurement of response to the prior course of therapy.

Where a response assessment is not undertaken, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

11219L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

11220M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

11197H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR
- Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs)

which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab,

etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR

- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3446J	1	3	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3447K	1	3	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3445H	2	3	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks

after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: First Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:(1) a completed authority prescription form; and(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

The application for first continuing treatment with this drug must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9090K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9460X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8638P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second

or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: First continuing treatment

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be used to determine response for all subsequent continuing treatments.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

The application for first continuing treatment following an initial treatment course must be made following a minimum of 12 weeks of treatment with this drug. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course.

If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was issued in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9086F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9456Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8779C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or

continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: First continuing treatment

Clinical criteria:

- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatments.

The application for first continuing treatment with this drug must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the first continuing treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the subsequent continuing Authority Required (in writing) treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9088H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9458T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9036N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Subsequent continuing treatment, whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Each application for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. Where a response assessment is not submitted the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Subsequent continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per subsequent continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Each application for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. Where a response assessment is not submitted the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the first continuing treatment, Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the first continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the subsequent continuing treatment Authority Required (in writing), Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the subsequent continuing treatment Authority Required (in writing), Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11224R	1	5	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11222P	1	5	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11223Q	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required

treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:(1) a completed authority prescription form; and(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the first continuing or subsequent continuing treatment criteria, the patient must have been assessed for response.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either(a) a total active joint count of at least 20 active (swollen and tender) joints; or(b) at least 4 active joints from the following list of major joints:(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note **Biosimilar prescribing policy** Prescribing of the biosimilar brand Brenzys is encouraged for treatment naive patients. Encouraging biosimilar prescribing for treatment naive patients is Government policy. A viable biosimilar market is expected to result in reduced costs for biological medicines, allowing the Government to reinvest in new treatments. Further information can be found on the Biosimilar Awareness Initiative webpage (www.health.gov.au/biosimilars).

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:(a) a completed authority prescription form; and(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the first continuing or subsequent continuing treatment criteria, the patient must have been assessed for response.

Where a response assessment is not undertaken, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9089J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9459W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8637N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	3	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or

(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and

(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant

restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment**.**

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5

years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note **Biosimilar prescribing policy** Prescribing of the biosimilar brand Brenzys is encouraged for treatment naive patients. Encouraging biosimilar prescribing for treatment naive patients is Government policy. A viable biosimilar market is expected to result in reduced costs for biological medicines, allowing the Government to reinvest in new treatments. Further information can be found on the Biosimilar Awareness Initiative webpage (www.health.gov.au/biosimilars).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not failed, or ceased to respond to, PBS-subsidised treatment with this drug for this condition during the current Treatment Cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy with this biological agent), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was accessed under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted, where applicable to the Department of Human Services.

Where this is the initial course of treatment with a particular biological agent (change of treatment) the assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was issued in this cycle and the date of the first application under a new cycle.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9087G	1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9457R	1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9035M	2	3	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of

treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: First continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

The application for first continuing treatment with this drug must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: First continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

The application for first continuing treatment with this drug must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the first continuing treatment, Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the first continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the subsequent continuing treatment Authority Required (in writing), Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the subsequent continuing treatment Authority Required (in writing), Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9431J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9462B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9429G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.

Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised

baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients or recommencement of treatment after a break of 5 years or more)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment for this condition with a biological disease modifying anti-rheumatic drug (bDMARD) in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Biosimilar prescribing policy Prescribing of the biosimilar brand Brenzys is encouraged for treatment naive patients. Encouraging biosimilar prescribing for treatment naive patients is Government policy. A viable biosimilar market is expected

to result in reduced costs for biological medicines, allowing the Government to reinvest in new treatments. Further information can be found on the Biosimilar Awareness Initiative webpage (www.health.gov.au/biosimilars).

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the first continuing or subsequent continuing treatment criteria, patients must have been assessed for response.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was issued in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment– Initial 1 (new patients or recommencement of treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) – balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 (new patient or recommencement of treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9085E	1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9455P	1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8778B	2	3	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment (whole body)

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have lesions present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with etanercept for this condition; OR
- Patient must not have received any PBS-subsidised treatment with etanercept for this condition for at least 12 months, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 2 of the following 3 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg or 10 mg per square metre weekly (whichever is lowest) for at least 6 weeks; and/or (iii) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Where treatment with any of the above-mentioned drugs was contraindicated according to the relevant TGA-approved Product Information, or where phototherapy was contraindicated, details must be provided at the time of application.

Where intolerance to phototherapy, methotrexate and/or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the parent or authorised guardian signed patient and prescriber acknowledgements.

Where a patient has had a 12 month treatment break, the length of the break is measured from the date the most recent treatment was stopped to the date of the application to re-commence treatment.

Note Details of acceptable toxicities including severity, associated with phototherapy, methotrexate and acitretin, can be found on the Department of Human Services website at www.humanservices.gov.au

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Whole body) - balance of first supply

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have received insufficient therapy under the Initial treatment (whole body) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy under the Re-treatment (whole body) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Whole body) - completion of course

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have received 16 weeks treatment under the Initial treatment (whole body) restriction for severe chronic plaque psoriasis; OR
- Patient must have received 16 weeks treatment under the Re-treatment (whole body) restriction for severe chronic plaque psoriasis, **AND**

- Patient must have demonstrated an adequate response to treatment, **AND**
- Patient must not receive more than 8 weeks of treatment with etanercept under this restriction.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, when compared with the pre-etanercept treatment baseline value.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) the completed current Psoriasis Area and Severity Index (PASI) calculation sheet including the date of assessment of the patient's condition.

The same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

A PASI assessment of the patient's response to the initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for a further 8 weeks of treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their initial 16 week treatment course to ensure continuity of treatment for those patients who meet the eligibility criterion for a further 8 weeks of PBS-subsidised etanercept treatment.

Note In circumstances where it is not possible to submit a response assessment after 12 weeks of treatment, please call the Department of Human Services on 1800 700 270 to discuss.

Note The Department of Human Services will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Re-treatment (Whole body)

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Population criteria:

- Patient must be under 18 years of age.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have a documented history of severe chronic plaque psoriasis of the whole body, **AND**
- Patient must have received prior PBS-subsidised treatment with etanercept for this condition in the past 12 months, **AND**
- Patient must have demonstrated a response to etanercept and experienced a disease flare; OR
- Patient must not have failed more than once to achieve an adequate response with etanercept, **AND**
- Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

A patient is eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior etanercept treatment, including date ceased.

Where a patient has had a treatment break the length of the break is measured from the date the most recent treatment was stopped to the date of the application for further treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment (Face, hand, foot)

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have the plaque or plaques of the face, or palm of hand or sole of foot present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with etanercept for this condition; OR
- Patient must not have received any PBS-subsidised treatment with etanercept for this condition for at least 12 months, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 2 of the following 3 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg or 10 mg per square metre weekly (whichever is lowest) for at least 6 weeks; and/or (iii)acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Where treatment with any of the above-mentioned drugs was contraindicated according to the relevant TGA-approved Product Information, or where phototherapy was contraindicated, details must be provided at the time of application.

Where intolerance to phototherapy, methotrexate and/or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets, and face, hand, foot area diagrams including the dates of assessment of the patient's condition

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the parent or authorised guardian signed patient and prescriber acknowledgements.

Where a patient has had a 12 month treatment break, the length of the break is measured from the date the most recent treatment was stopped to the date of the application to re-commence treatment.

Note Details of acceptable toxicities including severity, associated with phototherapy, methotrexate and acitretin, can be found on the Department of Human Services website at www.humanservices.gov.au

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment of Re-treatment (Face, hand, foot) - balance of first supply

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have received insufficient therapy under the Initial treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy under the Re-treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Face, hand, foot) - completion of course

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**
- Patient must have received 16 weeks treatment under the Initial treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis; OR
- Patient must have received 16 weeks treatment under the Re-treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis, **AND**
- Patient must have demonstrated an adequate response to treatment, **AND**
- Patient must not receive more than 8 weeks of treatment with etanercept under this restriction.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) the completed current Psoriasis Area and Severity Index (PASI) calculation sheet including the date of assessment of the patient's condition.

The same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

A PASI assessment of the patient's response to the initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for a further 8 weeks of treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their initial 16 week treatment course to ensure continuity of treatment for those patients who meet the eligibility criterion for a further 8 weeks of PBS-subsidised etanercept treatment.

Note In circumstances where it is not possible to submit a response assessment after 12 weeks of treatment, please call the Department of Human Services on 1800 700 270 to discuss.

Note The Department of Human Services will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Re-treatment (Face, hand, foot)

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months , must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Treatment criteria:

- Must be treated by a dermatologist.

Population criteria:

- Patient must be under 18 years of age.

Clinical criteria:

- The treatment must be as systemic monotherapy; OR
- The treatment must be in combination with methotrexate, **AND**

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with etanercept for this condition in the past 12 months, **AND**
- Patient must have demonstrated a response to etanercept and experienced a disease flare; OR
- Patient must not have failed more than once to achieve an adequate response with etanercept, **AND**
- Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

A patient is eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the 3 subscores are rated severe to very severe; or

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

The authority application must be made in writing and must include :

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area digrams including the dates of assessment of the patient's condition; and

(ii) details of prior etanercept treatment, including date ceased.

Where a patient has had a treatment break the length of the break is measured from the date the most recent treatment was stopped to the date of the application for further treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

1963H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1049.30	39.50	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

1964J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1049.30	39.50	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

1954W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	3	..	*1049.31	39.50	Enbrel [PF]

▪ ETANERCEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note **Biosimilar prescribing policy** Prescribing of the biosimilar brand Brenzys is encouraged for treatment naive patients. Encouraging biosimilar prescribing for treatment naive patients is Government policy. A viable biosimilar market is expected to result in reduced costs for biological medicines, allowing the Government to reinvest in new treatments. Further information can be found on the Biosimilar Awareness Initiative webpage (www.health.gov.au/biosimilars).

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**

- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note **Biosimilar prescribing policy** Prescribing of the biosimilar brand Brenzys is encouraged for treatment naive patients. Encouraging biosimilar prescribing for treatment naive patients is Government policy. A viable biosimilar market is expected to result in reduced costs for biological medicines, allowing the Government to reinvest in new treatments. Further information can be found on the Biosimilar Awareness Initiative webpage (www.health.gov.au/biosimilars).

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug for this condition under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment,

AND

- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9091L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9461Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	1049.30	39.50	[a] Brenzys [MK]	[a] Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9037P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	3	..	*1049.31	39.50	Enbrel [PF]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-

subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed

whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with golimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with golimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with golimumab.

If a patient fails to demonstrate a response to treatment with golimumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3428K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3429L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment

with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i)

hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3426H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3427J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1357.17	39.50	Simponi [JC]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3436W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3437X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3432P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3433Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1357.17	39.50	Simponi [JC]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

---

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

- Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3434R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3435T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1357.17	39.50	Simponi [JC]

▪ GOLIMUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3430M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	1357.17	39.50	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 0.5 mL syringe

3431N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	1357.17	39.50	Simponi [JC]

Interleukin inhibitors

▪ DACLIZUMAB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Multiple sclerosis
Treatment Phase: Initial treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must be ambulatory (without assistance or support).

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.
Patients should undergo monthly liver function testing while being treated with this drug.

Authority required
Multiple sclerosis
Treatment Phase: Continuing treatment
Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

- Must be treated by a neurologist.

Patients should undergo monthly liver function testing while being treated with this drug.

Authority required
Multiple sclerosis
Treatment Phase: Grandfathering treatment
Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years prior to initiation of this drug, **AND**
- Patient must have received treatment with this drug for this condition prior to 1 May 2017, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must be ambulatory (without assistance or support), **AND**
- The treatment must not exceed 24 weeks under this restriction.

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.
Patients should undergo monthly liver function testing while being treated with this drug.
A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

daclizumab 150 mg/mL injection, 1 mL injection device

11101G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	2232.85	39.50	Zinbryta [BD]

▪ IXEKIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological

agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 3, Whole body (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have been receiving treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must have had a Psoriasis Area and Severity Index (PASI) score of greater than 15 prior to commencing treatment with this drug, **AND**
- Patient must have demonstrated a response to treatment as specified in the criterion included in the restriction for continuing PBS-subsidised treatment with this drug (whole body), **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition at baseline (prior to initiation of therapy with this drug) and the most recent PASI assessment; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

The most recent PASI assessment must be no more than 1 month old at the time of application.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note A PASI assessment of the patient's response to this initial PBS-subsidised course of therapy must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 3, Face, hand, foot (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have been receiving treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must have had disease, prior to treatment with this drug, classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where: (i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling were rated as severe or very severe; or (ii) the skin area affected was 30% or more of the face, palm of a hand or sole of a foot, **AND**
- Patient must have demonstrated a response to treatment as specified in the criterion included in the restriction for continuing PBS-subsidised treatment with this drug (face, hand, foot), **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**

- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition at baseline (prior to initiation of therapy with this drug) and the most recent PASI assessment; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

The most recent PASI assessment must be no more than 1 month old at the time of application.

The PASI assessment must be performed on the same affected area as assessed at baseline or prior to initiation of treatment with this drug.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note A PASI assessment of the patient's response to this initial PBS-subsidised course of therapy must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 3, Whole body or Face, hand, foot (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) or Continuing treatment, Whole body or Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 3, Whole body (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 3, Face, hand, foot (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

ixekizumab 80 mg/mL injection, 2 x 1 mL injection devices

11033Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	3409.52	39.50	Taltz [LY]

▪ IXEKIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**

- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ixekizumab 80 mg/mL injection, 2 x 1 mL injection devices

11032P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	3409.52	39.50	Taltz [LY]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment - Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10494H	1	2	..	1586.28	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.

Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID,

at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have active, or had a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after a break of less than 5 years) restriction to complete 16 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the initial 1 or 2 restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

secukinumab 150 mg/mL injection, 1 mL injection device

10893H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	804.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with

that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencing treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete maximum of 16 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencing treatment after a break of less than 5 years) restriction to complete maximum of 16 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

10901R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1586.28	39.50	Cosentyx [NV]

secukinumab 150 mg/mL injection, 1 mL injection device

10898N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	804.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be

used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial treatment – initial 1 (new patients or patients recommencing treatment after a break of 5 years or more)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5

years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment - Initial 2 (change or recommencing treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

secukinumab 150 mg/mL injection, 1 mL injection device

10890E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4	..	..	*3170.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe active psoriatic arthritis

Treatment Phase: Initial 3 - grandfather treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received non-PBS treatment with this drug for this condition prior to 1 October 2016, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

The assessment of the patient's response to this PBS-subsidised course of therapy must be made within the 4 weeks prior to completion of the course of treatment. It is recommended that an application is submitted to the Department of Human Services no less than 2 weeks prior to the date the next dose is due in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to response, or to have failed to sustain a response to treatment with this drug.

Patients may qualify for PBS-subsidised treatment under this restriction once only. Further applications for treatment with this drug will be assessed under the continuing treatment restriction.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement; and

(4) the date of commencement of this drug; and

(5) results of the baseline patient assessment prior to commencing treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active psoriatic arthritis

Treatment Phase: Initial 3 (grandfather treatment) or Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 3 (grandfather patients) restriction to complete maximum of 24 weeks treatment, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

10899P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1586.28	39.50	Cosentyx [NV]

secukinumab 150 mg/mL injection, 1 mL injection device

10895K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	804.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-

trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: initial treatment - Initial 2 (change or recommencing treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10894J	4	..	..	*6191.63	39.50	Cosentyx [NV]

secukinumab 150 mg/mL injection, 1 mL injection device

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10900Q	4	..	..	*3170.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is

they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.

Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.

(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

10425Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1586.28	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 3 (grandfather treatment)

Clinical criteria:

- Patient must have confirmed ankylosing spondylitis, defined radiographically (plain X-ray) of Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, with the diagnosis confirmed by a rheumatologist, **AND**
- Patient must have been receiving treatment with this drug for this condition prior to 1 October 2016, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The baseline BASDAI assessment must be from immediately prior to commencing treatment with this drug. The patient's current BASDAI assessment and ESR and/or CRP measurements must be no more than 1 month old at the time of application. Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form; and

(c) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(d) a completed BASDAI Assessment Form; and

(e) a signed patient acknowledgment form;

(f) the date commencement of this drug;

(g) results of the baseline BASDAI assessment prior to commencing treatment with this drug.

Patients may qualify for PBS-subsidised treatment under this restriction once only. Further applications for treatment with this drug will be assessed under the continuing treatment restriction.

Note The assessment of the patient's response to this PBS-subsidised course of therapy must be made within the 4 weeks prior to completion of the course of treatment. It is recommended that an application is submitted to the Department of Human Services no less than 2 weeks prior to the date the next dose is due in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Note Special Pricing Arrangements apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 3 or Continuing treatment – balance of supply

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the initial 3 treatment restriction to complete 24 weeks of treatment, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

secukinumab 150 mg/mL injection, 1 mL injection device

10906B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	804.59	39.50	Cosentyx [NV]

▪ SECUKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.

Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or

(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or

(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or

(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.

Grandfather patients (ixekizumab only).

Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.

Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to

respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to

respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

secukinumab 150 mg/mL injection, 2 x 1 mL injection devices

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10910F	4	..	..	*6191.63	39.50	Cosentyx [NV]

▪ TOCILIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate

a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This

means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum number of repeats may be authorised.

Note No increase in the maximum quantity or number of units may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

tocilizumab 162 mg/0.9 mL injection, 4 x 0.9 mL syringes

10954M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	953.23	39.50	Actemra Subcutaneous Injection [RO]

▪ TOCILIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the

subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note No increase in the maximum number of repeats may be authorised.

Note No increase in the maximum quantity or number of units may be authorised.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with tocilizumab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:(1) completed authority prescription form(s); and(2) a completed Rheumatoid Arthritis initial PBS Authority Application - Supporting Information Form; and (3) a signed patient acknowledgement.If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition. The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application: an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either (a) a total active joint count of at least 20 active (swollen and tender) joints; or(b) at least 4 active joints from the following list of major joints:(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth). The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied. Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR

- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:(a) completed authority prescription form(s); and(b) a completed Rheumatoid Arthritis continuing PBS Authority Application - Supporting Information Form. Applications for a patient who has received PBS-subsidised treatment with tocilizumab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased. Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab. If a patient fails to demonstrate a response to a treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition. If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

tocilizumab 162 mg/0.9 mL injection, 4 x 0.9 mL syringes

10951J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	3	..	953.23	39.50	Actemra Subcutaneous Injection [RO]

▪ USTEKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe

chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is

important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 1 repeat will be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 1 repeat will be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

ustekinumab 45 mg/0.5 mL injection, 0.5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9305R	1	1	..	4346.86	39.50	Stelara [JC]

▪ USTEKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte

sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have been receiving treatment with this drug for this condition prior to 1 May 2016, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have demonstrated a response to treatment as specified in the criteria for continuing PBS-subsidised treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) or Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete the balance of supply may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.
No increase in the maximum number of repeats may be authorised.
Special Pricing Arrangements apply.

ustekinumab 45 mg/0.5 mL injection, 0.5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10767Q	1	1	..	4346.86	39.50	Stelara [JC]

▪ USTEKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or

continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more), Initial 2 (change or recommencement of treatment) - balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 28 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete the balance of supply may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authority approval for sufficient therapy to complete the balance of supply should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.
No increase in the maximum number of repeats may be authorised.
Special Pricing Arrangements apply.

ustekinumab 45 mg/0.5 mL injection, 0.5 mL vial

10774C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	4346.86	39.50	Stelara [JC]

▪ USTEKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-

subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to

respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**

- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment - Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 28 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

---

ustekinumab 45 mg/0.5 mL injection, 0.5 mL vial

9304Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	4346.86	39.50	Stelara [JC]

▪ USTEKINUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).

Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.

From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.

A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.

From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.

For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR

- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug, **AND**
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for 2 vials of 45 mg and no repeats.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent first dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR

- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats; up to 1 repeat will be authorised for patients whose dosing frequency is every 12 weeks. Up to a maximum of 2 repeats will be authorised for patients whose dosing frequency is every 8 weeks.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

Note No increase in the maximum quantity or number of units may be authorised.

Note Increase in the maximum number of repeats of up to 2 may be authorised in patients whose dosing frequency is every 8 weeks.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Initial PBS-subsidised treatment (Grandfather)

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously received non-PBS-subsidised therapy with this drug for this condition prior to 1 September 2017, **AND**
- Patient must be receiving treatment with ustekinumab at the time of application, **AND**
- Patient must have had a Crohn Disease Activity Index (CDAI) Score of greater than or equal to 300 prior to commencing treatment with this drug; OR
- Patient must have a documented history of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have a documented history and radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR

- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease Grandfathered PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats; up to 1 repeat will be authorised for patients whose dosing frequency is every 12 weeks. Up to a maximum of 2 repeats will be authorised for patients whose dosing frequency is every 8 weeks

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note No applications for increased maximum quantities will be authorised.

Note Increase in the maximum number of repeats of up to two may be authorised in patients whose dosing frequency is every 8 weeks.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply for Initial treatment, Continuing treatment or Grandfathered treatment

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 16 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug under the Grandfathered treatment restriction to complete 24 weeks of treatment.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Authority approval for sufficient therapy to complete the balance of supply may be requested by telephone by contacting the Department of Human Services

Note No increase in the maximum quantity or number of units may be authorised.

Note Applications for authority to prescribe may be made by phone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

ustekinumab 45 mg/0.5 mL injection, 0.5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11178H	2	..	..	*8614.15	39.50	Stelara [JC]

Calcineurin inhibitors

▪ CICLOSPORIN

Caution Careful monitoring of patients is mandatory.

ciclosporin 10 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8657P	2	3	..	*91.09	39.50	Neoral 10 [NV]

ciclosporin 50 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8659R	2	3	..	*155.25	39.50	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 50 [NV]

ciclosporin 100 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8660T	2	3	..	*308.81	39.50	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 100 [NV]

ciclosporin 25 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8658Q	2	3	..	*80.37	39.50	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 25 [NV]

ciclosporin 100 mg/mL oral liquid, 50 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8661W	2	3	..	*707.63	39.50	Neoral [NV]

▪ TACROLIMUS

Caution Careful monitoring of patients is mandatory.

tacrolimus 1 mg modified release capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5300Y	1	3	..	152.63	39.50	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 5 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8648E	1	3	..	614.87	39.50	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 500 microgram modified release capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5299X	1	3	..	51.43	39.50	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 750 microgram capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10870D	1	3	..	213.45	39.50	Tacrolimus Sandoz [SZ]

tacrolimus 5 mg modified release capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5451X	1	3	..	422.35	39.50	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 500 microgram capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8646C	1	3	..	129.04	39.50	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 0.5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 1 mg capsule, 100

8647D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	248.95	39.50	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 1 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 2 mg capsule, 100

10871E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	561.21	39.50	Tacrolimus Sandoz [SZ]

Other immunosuppressants

▪ AZATHIOPRINE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

azathioprine 25 mg tablet, 100

2688L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.25	24.46	[a] APO-Azathioprine [TX] [a] Azathioprine Sandoz [SZ]	[a] Azathioprine GH [GQ] [a] Imuran [AS]

azathioprine 50 mg tablet, 100

2687K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	31.80	33.01	[a] APO-Azathioprine [TX] [a] Azathioprine AN [EA] [a] Azathioprine Sandoz [SZ] [a] Imuran [AS]	[a] Azapin [RW] [a] Azathioprine GH [GQ] [a] Imazan [ER] [a] Thioprine 50 [AF]

▪ METHOTREXATE

methotrexate 10 mg tablet, 15

2272N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	3	..	23.19	24.40	Methoblastin [PF]

methotrexate 2.5 mg tablet, 30

1622J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	16.92	18.13	Methoblastin [PF]

▪ METHOTREXATE

Restricted benefit
Patients requiring doses greater than 20 mg per week

methotrexate 10 mg tablet, 50

1623K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	51.41	39.50	Methoblastin [PF]

▪ PIRFENIDONE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Idiopathic pulmonary fibrosis
Treatment Phase: Initial treatment 1 - new patient
Clinical criteria:

- The condition must be diagnosed through a multidisciplinary team, **AND**
- Patient must have chest high resolution computed tomography (HRCT) consistent with diagnosis of idiopathic pulmonary fibrosis within the previous 12 months, **AND**
- Patient must have a forced vital capacity (FVC) greater than or equal to 50% predicted for age, gender and height, **AND**
- Patient must have a forced expiratory volume in 1 second to forced vital capacity ratio (FEV1/FVC) greater than 0.7, **AND**
- Patient must have diffusing capacity of the lungs for carbon monoxide (DLCO) corrected for haemoglobin equal to or greater than 30%, **AND**
- Patient must not have interstitial lung disease due to other known causes including domestic and occupational environmental exposures, connective tissue disease, or drug toxicity, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

A multidisciplinary team is defined as comprising of at least a specialist respiratory physician, a radiologist and where histological material is considered, a pathologist. If attendance is not possible because of geographical isolation, consultation with a multidisciplinary team is required for diagnosis.

Patient must have not have an acute respiratory infection at the time of FVC testing.

Applications for authorisation of initial treatment must be in writing and must include:

a) a completed authority prescription form; and

b) a completed IPF Authority Application Supporting Information Form; and

c) a signed patient acknowledgement.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Initial treatment 2 - change or re-commencement of treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with nintedanib or pirfenidone for this condition, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Idiopathic pulmonary fibrosis

Treatment Phase: Initial treatment 3 - Grandfathering treatment

Treatment criteria:

- Must be treated by a respiratory physician or specialist physician, or in consultation with a respiratory physician or specialist physician.

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 July 2017, **AND**
- The condition must have been diagnosed through a multidisciplinary team, **AND**
- Patient must have had a forced vital capacity (FVC) greater than or equal to 50% predicted for age, gender and height at the time treatment with this drug for this condition was initiated, **AND**
- Patient must have had a forced expiratory volume in 1 second (FEV1)/FVC ratio greater than 0.7 at the time treatment with this drug for this condition was initiated, **AND**
- Patient must have had diffusing capacity of the lungs for carbon monoxide (DLCO) corrected for haemoglobin equal to or greater than 30% at the time treatment with this drug for this condition was initiated, **AND**
- Patient must not have interstitial lung disease due to other known causes including domestic and occupational environmental exposures, connective tissue disease, or drug toxicity, **AND**
- The treatment must be the sole PBS-subsidised treatment for this condition.

A multidisciplinary team is defined as comprising of at least a specialist respiratory physician, a radiologist and where histological material is considered, a pathologist. If attendance is not possible because of geographical isolation, consultation with a multidisciplinary team is required for diagnosis.

Patient must have not have an acute respiratory infection at the time of FVC testing.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the continuing treatment criteria or change or recommencement of treatment criteria.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Applications for authorisation of initial treatment must be in writing and must include:
a) a completed authority prescription form; and
b) a completed IPF Authority Application Supporting Information Form; and
c) a signed patient acknowledgement.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pirfenidone 267 mg capsule, 270

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11136D	1	5	..	3064.52	39.50	Esbriet [RO]

MUSCULO-SKELETAL SYSTEM

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS

Acetic acid derivatives and related substances

DICLOFENAC

diclofenac sodium 100 mg suppository, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1302M NP MW	2	3	..	*27.51	28.72	Voltaren 100 [NV]

diclofenac sodium 100 mg suppository, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5079H DP	2	..	..	*27.51	28.72	Voltaren 100 [NV]

DICLOFENAC

Restricted benefit
Chronic arthropathies (including osteoarthritis)
Clinical criteria:
- The condition must have an inflammatory component.

Restricted benefit
Bone pain
Clinical criteria:
- The condition must be due to malignant disease.

diclofenac sodium 50 mg enteric tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1300K NP	1	3	..	13.14	14.35	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ] [a] Pharmacor Diclofenac 50 [CR]	[a] Clonac 50 [RW] [a] Diclofenac AN [EA] [a] Fenac [AF]
			[B]3.46	16.60	14.35	[a] Voltaren 50 [NV]	

diclofenac sodium 25 mg enteric tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1299J NP	2	3	..	*14.03	15.24	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ]	[a] Clonac 25 [RW] [a] Diclofenac AN [EA] [a] Fenac 25 [AF]
			[B]3.44	*17.47	15.24	[a] Voltaren 25 [NV]	

DICLOFENAC

Restricted benefit
Chronic arthropathies (including osteoarthritis)
Clinical criteria:
- The condition must have an inflammatory component.

Restricted benefit
Bone pain
Clinical criteria:

- The condition must be due to malignant disease.

diclofenac sodium 50 mg enteric tablet, 50

5077F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.14	14.35	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ] [a] Pharmacor Diclofenac 50 [CR]	[a] Clonac 50 [RW] [a] Diclofenac AN [EA] [a] Fenac [AF]
			[B]3.46	16.60	14.35	[a] Voltaren 50 [NV]	

diclofenac sodium 25 mg enteric tablet, 50

5076E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	2	..	..	*14.03	15.24	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ]	[a] Clonac 25 [RW] [a] Diclofenac AN [EA] [a] Fenac 25 [AF]
			[B]3.44	*17.47	15.24	[a] Voltaren 25 [NV]	

▪ INDOMETACIN

indometacin 100 mg suppository, 20

2757D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*25.07	26.28	Indocid [AS]

indometacin 100 mg suppository, 20

5128X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	2	..	..	*25.07	26.28	Indocid [AS]

▪ INDOMETACIN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

indometacin 25 mg capsule, 50

2454E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*16.69	17.90	[a] Arthrexin [AF]
			[B]4.04	*20.73	17.90	[a] Indocid [AS]

▪ INDOMETACIN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

indometacin 25 mg capsule, 50

5126T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	2	..	..	*16.69	17.90	[a] Arthrexin [AF]
			[B]4.04	*20.73	17.90	[a] Indocid [AS]

Oxicams

▪ MELOXICAM

Note The use of this drug for the treatment of the following conditions is not subsidised through the PBS:
(a) acute pain;
(b) soft tissue injury;
(c) arthrosis without an inflammatory component.

Note Pharmaceutical benefits that have the form meloxicam tablet 7.5 mg and pharmaceutical benefits that have the form meloxicam capsule 7.5 mg are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the form meloxicam tablet 15 mg and pharmaceutical benefits that have the form meloxicam capsule 15 mg are equivalent for the purposes of substitution.

Restricted benefit

Osteoarthritis

Clinical criteria:

- Patient must be symptomatic.

Restricted benefit

Rheumatoid arthritis

Clinical criteria:

- Patient must be symptomatic.

meloxicam 15 mg tablet, 30

8562P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	15.18	16.39	[a] APO-Meloxicam [TX]	[a] Chem mart Meloxicam 15 mg [CH]
						[a] Meloxiauro 15 [DO]	[a] Meloxibell [GQ]
						[a] Meloxicam AN [EA]	[a] Meloxicam-GA [ED]
						[a] Meloxicam Ranbaxy [RA]	[a] Meloxicam Sandoz [SZ]
						[a] Movalis 15 [RW]	[a] Moxicam 15 [AF]
						[a] Pharmacor Meloxicam 15 [CR]	[a] Terry White Chemists Meloxicam 15 mg [TW]
			[B]2.50	17.68	16.39	[a] Mobic [BY]	

meloxicam 7.5 mg capsule, 30

8887R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	13.89	15.10	[a] APO-Meloxicam [TX]	[a] Chem mart Meloxicam [CH]
						[a] Meloxicam Sandoz [SZ]	[a] Movalis 7.5 [RW]
						[a] Moxicam [AF]	[a] Terry White Chemists Meloxicam [TW]
			[B]2.50	16.39	15.10	[a] Mobic [BY]	

meloxicam 7.5 mg tablet, 30

8561N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	13.89	15.10	[a] APO-Meloxicam [TX]	[a] Chem mart Meloxicam 7.5 mg [CH]
						[a] Meloxiauro 7.5 [DO]	[a] Meloxibell [GQ]
						[a] Meloxicam AN [EA]	[a] Meloxicam-GA [ED]
						[a] Meloxicam Ranbaxy [RA]	[a] Meloxicam Sandoz [SZ]
						[a] Movalis 7.5 [RW]	[a] Moxicam 7.5 [AF]
						[a] Pharmacor Meloxicam 7.5 [CR]	[a] Terry White Chemists Meloxicam 7.5 mg [TW]
			[B]2.50	16.39	15.10	[a] Mobic [BY]	

meloxicam 15 mg capsule, 30

8888T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	15.18	16.39	[a] APO-Meloxicam [TX]	[a] Chem mart Meloxicam [CH]
						[a] Meloxicam Sandoz [SZ]	[a] Movalis 15 [RW]
						[a] Moxicam [AF]	[a] Terry White Chemists Meloxicam [TW]
			[B]2.50	17.68	16.39	[a] Mobic [BY]	

▪ PIROXICAM

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

piroxicam 10 mg dispersible tablet, 50

1895R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	16.12	17.33	Mobilis D-10 [AF]

piroxicam 10 mg dispersible tablet, 50

5201R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	16.12	17.33	Mobilis D-10 [AF]

piroxicam 20 mg capsule, 25

1898X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	15.87	17.08	[a] GenRx Piroxicam [GX]	[a] Mobilis 20 [AF]
			[B]8.00	23.87	17.08	[a] Feldene [PF]	

piroxicam 20 mg capsule, 25

5204X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	15.87	17.08	[a] GenRx Piroxicam [GX]	[a] Mobilis 20 [AF]
			[B]8.00	23.87	17.08	[a] Feldene [PF]	

piroxicam 20 mg dispersible tablet, 25

1896T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	15.87	17.08	[a] Mobilis D-20 [AF]
			[B]8.00	23.87	17.08	[a] Feldene-D [PF]

piroxicam 20 mg dispersible tablet, 25

5202T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	15.87	17.08	[a] Mobilis D-20 [AF]
			[B]8.00	23.87	17.08	[a] Feldene-D [PF]

piroxicam 10 mg capsule, 50

1897W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	16.12	17.33	[a] GenRx Piroxicam [GX]	[a] Mobilis 10 [AF]
			[B]8.00	24.12	17.33	[a] Feldene [PF]	

piroxicam 10 mg capsule, 50

5203W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	16.12	17.33	[a] GenRx Piroxicam [GX]	[a] Mobilis 10 [AF]
			[B]8.00	24.12	17.33	[a] Feldene [PF]	

Propionic acid derivatives

▪ IBUPROFEN

ibuprofen 400 mg tablet, 30

3192B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	13.01	14.22	[a] APO-Ibuprofen 400 [TX]	[a] Brufen [GO]

ibuprofen 400 mg tablet, 30

5124Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.01	14.22	[a] APO-Ibuprofen 400 [TX]	[a] Brufen [GO]

▪ IBUPROFEN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

ibuprofen 400 mg tablet, 30

3190X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	3	..	*16.84	18.05	[a] APO-Ibuprofen 400 [TX]	[a] Brufen [GO]

▪ IBUPROFEN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

ibuprofen 400 mg tablet, 30

5123P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	3	..	..	*16.84	18.05	[a] APO-Ibuprofen 400 [TX]	[a] Brufen [GO]

▪ KETOPROFEN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

ketoprofen 200 mg modified release capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1590Q NP	1	3	..	22.12	23.33	[a] Oruvail SR [AV]
			[B]1.92	24.04	23.33	[a] Orudis SR 200 [SW]

ketoprofen 200 mg modified release capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5136H DP	1	..	..	22.12	23.33	[a] Oruvail SR [AV]
			[B]1.92	24.04	23.33	[a] Orudis SR 200 [SW]

▪ NAPROXEN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

naproxen 1 g modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1615B NP	1	3	..	17.65	18.86	[a] Proxen SR 1000 [IY]
			[B]1.12	18.77	18.86	[a] Naprosyn SR1000 [IX]

naproxen 250 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1674D NP	2	3	..	*18.35	19.56	[a] Inza 250 [AF]
			[B]2.24	*20.59	19.56	[a] Naprosyn [IX]

naproxen 500 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1659H NP	1	3	..	16.46	17.67	[a] Inza 500 [AF]
			[B]1.12	17.58	17.67	[a] Naprosyn [IX]

naproxen 750 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1614Y NP	1	3	..	16.01	17.22	[a] Proxen SR 750 [IY]
			[B]1.06	17.07	17.22	[a] Naprosyn SR750 [IX]

▪ NAPROXEN

Authority required (STREAMLINED)

4159

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component, **AND**
- Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

Authority required (STREAMLINED)

4124

Bone pain

Clinical criteria:

- The condition must be due to malignant disease, **AND**
- Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

naproxen 125 mg/5 mL oral liquid, 474 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1658G NP	‡1	3	..	121.27	39.50	Phebra Naproxen Suspension [PL]

▪ NAPROXEN

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

naproxen 1 g modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5179N DP	1	..	..	17.65	18.86	[a] Proxen SR 1000 [IY]
			[B]1.12	18.77	18.86	[a] Naprosyn SR1000 [IX]

naproxen 250 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5176K DP	2	..	..	*18.35	19.56	[a] Inza 250 [AF]
			[B]2.24	*20.59	19.56	[a] Naprosyn [IX]

naproxen 500 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5177L DP	1	..	..	16.46	17.67	[a] Inza 500 [AF]
			[B]1.12	17.58	17.67	[a] Naprosyn [IX]

naproxen 750 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5178M DP	1	..	..	16.01	17.22	[a] Proxen SR 750 [IY]
			[B]1.06	17.07	17.22	[a] Naprosyn SR750 [IX]

▪ NAPROXEN

Note Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

naproxen sodium 550 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1795L NP	1	3	..	16.61	17.82	[a] Crysanal [IY]
			[B]1.89	18.50	17.82	[a] Anaprox 550 [IX]

▪ NAPROXEN

Note Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

Restricted benefit

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

- The condition must have an inflammatory component.

Restricted benefit

Bone pain

Clinical criteria:

- The condition must be due to malignant disease.

naproxen sodium 550 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5186Y DP	1	..	..	16.61	17.82	[a] Crysanal [IY]
			[B]1.89	18.50	17.82	[a] Anaprox 550 [IX]

Fenamates

▪ MEFENAMIC ACID

Restricted benefit

Dysmenorrhoea

Restricted benefit

Menorrhagia

mefenamic acid 250 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1824B NP	1	2	..	20.80	22.01	Ponstan [PF]

Coxibs

▪ CELECOXIB

Note The use of this drug for the treatment of the following conditions is not subsidised through the PBS:
(a) acute pain;
(b) soft tissue injury;
(c) arthrosis without an inflammatory component.

Restricted benefit
Osteoarthritis
Clinical criteria:
- The treatment must be for symptomatic treatment.

Restricted benefit
Rheumatoid arthritis
Clinical criteria:
- The treatment must be for symptomatic treatment.

celecoxib 100 mg capsule, 60

8439E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	18.03	19.24	[a] APO-Celecoxib [TX]	[a] Blooms the Chemist Celecoxib [IB]
						[a] Celaxib [AF]	[a] Celebrex [PF]
						[a] Celecoxib AN [EA]	[a] Celecoxib GH [GQ]
						[a] Celecoxib RBX [RA]	[a] Celecoxib Sandoz [SZ]
						[a] Celexi [RW]	[a] Chem mart Celecoxib [CH]
						[a] Terry White Chemists Celecoxib [TW]	

celecoxib 200 mg capsule, 30

8440F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	18.03	19.24	[a] APO-Celecoxib [TX]	[a] Blooms the Chemist Celecoxib [IB]
						[a] Celaxib [AF]	[a] Celebrex [PF]
						[a] Celecoxib AN [EA]	[a] Celecoxib GH [GQ]
						[a] Celecoxib RBX [RA]	[a] Celecoxib Sandoz [SZ]
						[a] Celexi [RW]	[a] Chem mart Celecoxib [CH]
						[a] Terry White Chemists Celecoxib [TW]	

SPECIFIC ANTIRHEUMATIC AGENTS

Quinolines

▪ HYDROXYCHLOROQUINE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

hydroxychloroquine sulfate 200 mg tablet, 100

1512N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	25.15	26.36	[a] APO- Hydroxychloroquine [TX]	[a] Hequinel [RW]
						[a] Hydroxychloroquine AN [EA]	[a] Hydroxychloroquine GH [GQ]
						[a] Hydroxychloroquine RBX [RA]	[a] Plaquenil [SW]

Gold preparations

▪ AURANOFIN

Caution Regular blood and urine checks are essential.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

auranofin 3 mg capsule, 60

2022K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	773.65	39.50	Ridaura [BZ]

auranofin 3 mg tablet, 60

1095P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	238.01	39.50	Ridaura [GH]

▪ SODIUM AUROTHIOMALATE

Caution Regular blood and urine checks are essential.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

sodium aurothiomalate 50 mg/0.5 mL injection, 10 x 0.5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2018F NP	1	1	..	137.22	39.50	Myocrisin [SW]

sodium aurothiomalate 10 mg/0.5 mL injection, 10 x 0.5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2016D NP	1	..	..	77.48	39.50	Myocrisin [SW]

sodium aurothiomalate 20 mg/0.5 mL injection, 10 x 0.5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2017E NP	1	1	..	113.23	39.50	Myocrisin [SW]

Penicillamine and similar agents

▪ PENICILLAMINE

Caution Regular blood and urine checks are essential.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

penicillamine 250 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2838J NP	1	1	..	51.35	39.50	D-Penamine [AL]

penicillamine 125 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2721F NP	1	1	..	45.17	39.50	D-Penamine [AL]

▪ MUSCLE RELAXANTS

MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS

Other centrally acting agents

▪ BACLOFEN

baclofen 10 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2729P NP	1	5	..	21.07	22.28	[a] APO-Baclofen [TX] [a] GenRx Baclofen [GX] [a] Stelax 10 [RW]	[a] Clofen 10 [AF] [a] Lioresal 10 [NV]

baclofen 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2730Q NP	1	5	..	32.90	34.11	[a] APO-Baclofen [TX] [a] GenRx Baclofen [GX] [a] Stelax 25 [RW]	[a] Clofen 25 [AF] [a] Lioresal 25 [NV]

MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS

Dantrolene and derivatives

▪ DANTROLENE

Restricted benefit
Chronic spasticity

dantrolene sodium 25 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1779P NP	1	2	..	75.67	39.50	Dantrium [PF]

dantrolene sodium 50 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1780Q NP	1	2	..	76.20	39.50	Dantrium [PF]

ANTIGOUT PREPARATIONS

ANTIGOUT PREPARATIONS

Preparations inhibiting uric acid production

ALLOPURINOL

Note The dose should be adjusted in accordance with renal function.

allopurinol 300 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2604C NP	1	2	..	14.61	15.82	[a] Allopurinol APOTEX [GX] [a] Allosig [RF] [a] Chem mart Allopurinol [CH] [a] Terry White Chemists Allopurinol [TW]	[a] Allopurinol Sandoz [SZ] [a] APO-Allopurinol [TX] [a] Progout 300 [AF]
			[B]3.48	18.09	15.82	[a] Zyloprim [RW]	

ALLOPURINOL

Note The dose should be adjusted in accordance with renal function.

Note For item codes 2600W and 1557Y, pharmaceutical benefits that have the form tablet 100 mg are equivalent for the purposes of substitution.

allopurinol 100 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1557Y NP	2	2	..	*15.95	17.16	[a] Progout 100 [AF]

allopurinol 100 mg tablet, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2600W NP	1	2	..	15.95	17.16	[a] Allopurinol APOTEX [GX] [a] Allosig [RF] [a] Chem mart Allopurinol [CH] [a] Terry White Chemists Allopurinol [TW]	[a] Allopurinol Sandoz [SZ] [a] APO-Allopurinol [TX] [a] Progout 100 [AF]
			[B]3.47	19.42	17.16	[a] Zyloprim [RW]	

FEBUXOSTAT

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required
Chronic gout
Clinical criteria:

- The condition must be either chronic gouty arthritis or chronic tophaceous gout, **AND**
- Patient must have a medical contraindication to allopurinol; OR
- Patient must have a documented history of allopurinol hypersensitivity syndrome; OR
- Patient must have an intolerance to allopurinol necessitating permanent treatment discontinuation.

febuxostat 80 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10445R NP	1	5	..	50.94	39.50	Adenuric [FK]

Preparations increasing uric acid excretion

PROBENECID

probenecid 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1940D NP	1	5	..	70.91	39.50	Pro-Cid [PL]

Preparations with no effect on uric acid metabolism

▪ COLCHICINE

colchicine 500 microgram tablet, 30

3410L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	15.07	16.28	[a] Lengout [LN]
			[B]2.90	17.97	16.28	[a] Colgout [AS]

▪ DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

▪ ALENDRONATE

Restricted benefit

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Restricted benefit

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Restricted benefit

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

---

alendronate 70 mg tablet, 4

8511Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.00	16.21	[a] Alendrobell 70mg [GQ]	[a] Alendronate Sandoz [SZ]
						[a] Alendro Once Weekly [RW]	[a] APO-Alendronate [TX]
						[a] Densate 70 [DO]	[a] Fonat [AL]

▪ CLODRONATE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

Restricted benefit

Multiple myeloma

Restricted benefit

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

clodronate sodium 800 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8265B NP	1	2	..	365.66	39.50	Bonefos 800 mg [BN]

clodronate sodium 400 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8132B NP	1	2	..	309.26	39.50	Bonefos [BN]

▪ IBANDRONATE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

ibandronate 50 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9357L NP	1	2	..	317.38	39.50	Bondronat [RO]

▪ PAMIDRONATE DISODIUM

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Symptomatic Paget disease of bone

pamidronate disodium 60 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8463K NP	1	..	..	70.51	39.50	Pamisol [PF]

pamidronate disodium 15 mg/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8461H NP	4	..	..	*70.51	39.50	Pamisol [PF]

pamidronate disodium 30 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8462J NP	2	..	..	*70.51	39.50	Pamisol [PF]

▪ RISEDRONATE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Symptomatic Paget disease of bone

risedronate sodium 30 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8482K NP	1	1	..	175.09	39.50	Actonel [UA]

▪ RISEDRONATE

Restricted benefit

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Restricted benefit

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Restricted benefit

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

risedronate sodium 35 mg tablet, 4

8621R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	35.10	36.31	[a] Acris Once-a-Week [AF] [a] Risedronate AN [EA] [a] Risedro once a week [RW]	[a] APO-Risedronate [TX] [a] Risedronate Sandoz [SZ]

risedronate sodium 150 mg tablet, 1

9391G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	37.12	38.33	[a] Acris Once-a-Month [AF] [a] APO-Risedronate [TX]	[a] Actonel Once-a-Month [UA] [a] ATELVIA ONCE-A-MONTH [GN]

RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4

8972F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	35.10	36.31	Actonel EC [UA]

risedronate sodium 5 mg tablet, 28

8481J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	35.10	36.31	Actonel [UA]

▪ ZOLEDRONIC ACID

Note Pharmaceutical benefits that have the form zoledronic acid injection 5 mg/100 mL vial and pharmaceutical benefits that have the form zoledronic acid injection 5 mg/100 mL bag are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

5710

Symptomatic Paget disease of bone

Only 1 treatment each year per patient will be PBS-subsidised

zoledronic acid 5 mg/100 mL injection, 100 mL bag

10571J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	370.31	39.50	[a] Ostira [PF]

zoledronic acid 5 mg/100 mL injection, 100 mL vial

9350D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	370.31	39.50	[a] Aclasta [HX] [a] Zoledasta [TX]	[a] Osteovan [SZ]

▪ ZOLEDRONIC ACID

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Note Pharmaceutical benefits that have the form zoledronic acid injection 5 mg/100 mL vial and pharmaceutical benefits that have the form zoledronic acid injection 5 mg/100 mL bag are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

6308

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**
- Patient must not receive more than one PBS-subsidised treatment per year.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6313

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -3.0 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**
- Patient must not receive more than one PBS-subsidised treatment per year.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6318

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**
- Patient must not receive more than one PBS-subsidised treatment per year.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

zoledronic acid 5 mg/100 mL injection, 100 mL bag

10555M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	370.31	39.50	[a] Ostira [PF]

zoledronic acid 5 mg/100 mL injection, 100 mL vial

9288W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	370.31	39.50	[a] Aclasta [HX] [a] Zoledasta [TX]	[a] Osteovan [SZ]

Bisphosphonates, combinations

▪ ALENDRONATE + COLECALCIFEROL

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6306

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6325

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6319

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

alendronate 70 mg + colecalciferol 140 microgram (5600 units) tablet, 4

9183H (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	17.94	19.15	[a] Alendronate plus D3-DRLA [RZ] [a] APO-Alendronate Plus D3 70 mg/140 mcg [TX] [a] Dronalen Plus [AL] [a] Terry White Chemists Alendronate Plus D3 70 mg/140 mcg [TW]	[a] Alendronate Plus D3 Sandoz [SZ] [a] Chem mart Alendronate Plus D3 70 mg/140 mcg [CH] [a] FonatPlus [AF]
		[B]4.00	21.94	19.15	[a] Fosamax Plus 70 mg/140 mcg [MK]	

▪ ALENDRONATE + COLECALCIFEROL

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Note Fosamax Plus provides a supplemental intake of vitamin D. The amount of colecalciferol present in Fosamax Plus is not sufficient to use as the sole treatment for correction of vitamin D deficiency.

Authority required (STREAMLINED)

6307

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6320

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6315

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

alendronate 70 mg + colecalciferol 70 microgram tablet, 4

9012H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.94	19.15	[a] Alendronate plus D3-DRLA [RZ] [a] APO-Alendronate Plus D3 70 mg/70 mcg [TX] [a] FonatPlus [AF]	[a] Alendronate Plus D3 Sandoz [SZ] [a] Chem mart Alendronate Plus D3 70 mg/70 mcg [CH] [a] Terry White Chemists Alendronate Plus D3 70 mg/70 mcg [TW]
			[B]4.00	21.94	19.15	[a] Fosamax Plus [MK]	

▪ ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6306

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6325

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6319

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack

9351E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	22.83	24.04	[a] Dronalen Plus D-Cal [AF]	[a] ReddyMax Plus D-Cal [RZ]
			[B]1.88	24.71	24.04	[a] Fosamax Plus D-Cal [MK]	

▪ RISEDRONATE (&) CALCIUM CARBONATE

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6306

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6325

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6319

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

8973G (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	35.10	36.31	Actonel EC Combi [UA]

risedronate sodium 35 mg tablet [4] (&) calcium (as carbonate) 500 mg tablet [24], 28

8899J (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	35.10	36.31	Acris Combi [AF]

▪ RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6306

Corticosteroid-induced osteoporosis

Clinical criteria:

- Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**
- Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6325

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6319

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

8974H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	35.10	36.31	Actonel EC Combi D [UA]

Other drugs affecting bone structure and mineralization

▪ CALCITRIOL

Authority required (STREAMLINED)

5401

Hypocalcaemia

Clinical criteria:

- The condition must be due to renal disease.

Authority required (STREAMLINED)

5255

Hypoparathyroidism

Authority required (STREAMLINED)

5089

Hypophosphataemic rickets

Authority required (STREAMLINED)

5114

Vitamin D-resistant rickets

Authority required (STREAMLINED)

5402

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

calcitriol 0.25 microgram capsule, 100

2502Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	27.21	28.42	[a] APO-Calcitriol [TX] [a] Calcitriol AN [EA] [a] Sical [AF]	[a] Calciprox [ER] [a] Kosteo [RW]
			[B]2.29	29.50	28.42	[a] Rocaltrol [RO]	

▪ DENOSUMAB

Note Denosumab is not PBS-subsidised for use in patients who have undergone curative surgical resection.

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4504

Giant cell tumour of bone

Clinical criteria:

- Patient must be one in whom surgical resection is not feasible; OR
- Patient must be one in whom surgical resection is possible but surgery would result in significant morbidity.

Population criteria:

- Patient must be an adult; OR
- Patient must be a skeletally mature adolescent.

denosumab 120 mg/1.7 mL injection, 1.7 mL vial

10061M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	501.67	39.50	Xgeva [AN]

▪ DENOSUMAB

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4158

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

Authority required (STREAMLINED)

4150

Bone metastases

Clinical criteria:

- The condition must be due to castration-resistant prostate cancer.

denosumab 120 mg/1.7 mL injection, 1.7 mL vial

5110Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	501.67	39.50	Xgeva [AN]

▪ DENOSUMAB

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6548

Osteoporosis

Population criteria:

- Patient must be aged 70 years or older.

Clinical criteria:

- Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

6524

Established osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

denosumab 60 mg/mL injection, 1 mL syringe

5457F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	271.49	39.50	Prolia [AN]

▪ RALOXIFENE

Note Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride and zoledronic acid.

Authority required (STREAMLINED)

6314

Established post-menopausal osteoporosis

Clinical criteria:

- Patient must have fracture due to minimal trauma, **AND**
- Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

raloxifene hydrochloride 60 mg tablet, 28

8363E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	44.85	39.50	[a] APO-Raloxifene [TX]	[a] Evifyne [EL]
					[a] Evista [LY]	[a] Fixta 60 [DO]
					[a] Raloxifene AMNEAL [ED]	[a] Raloxifene AN [EA]

▪ TERIPARATIDE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Severe established osteoporosis

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist; OR
- Must be treated by a consultant physician.

Clinical criteria:

- Patient must be at very high risk of fracture, **AND**
- Patient must have a bone mineral density (BMD) T-score of -3.0 or less, **AND**
- Patient must have had 2 or more fractures due to minimal trauma, **AND**
- Patient must have experienced at least 1 symptomatic new fracture after at least 12 months continuous therapy with an anti-resorptive agent at adequate doses, **AND**
- The treatment must be the sole PBS-subsidised agent, **AND**
- The treatment must not exceed a lifetime maximum of 18 months therapy.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

If treatment with anti-resorptive therapy is contraindicated according to the relevant TGA-approved Product Information, details of the contraindication must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

If an intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use of one anti-resorptive agent, alternate anti-resorptive agents must be trialled so that the patient achieves the minimum requirement of 12 months continuous therapy**.** Details must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

Anti-resorptive therapies for osteoporosis and their adequate doses which will be accepted for the purposes of administering this restriction are alendronate sodium 10 mg per day or 70 mg once weekly, risedronate sodium 5 mg per day or 35 mg once weekly or 150 mg once monthly, raloxifene hydrochloride 60 mg per day (women only), denosumab 60 mg once every 6 months and zoledronic acid 5 mg per annum.

Details of prior anti-resorptive therapy, fracture history including the date(s), site(s), the symptoms associated with the fracture(s) which developed after at least 12 months continuous anti-resorptive therapy and the score of the qualifying BMD measurement must be provided at the time of application.

Note Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Authority required

Severe established osteoporosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- The treatment must not exceed a lifetime maximum of 18 months therapy.

Note Up to a maximum of 18 pens will be reimbursed through the PBS.

teriparatide 20 microgram/dose injection, 28 doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9411H	1	5	..	411.80	39.50	Forteo [LY]

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

CODEINE

codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1214X NP	1	..	..	20.50	21.71	Fawns and McAllan Proprietary Limited [FM]

CODEINE

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5063L DP	1	..	..	20.50	21.71	Fawns and McAllan Proprietary Limited [FM]

▪ HYDROMORPHONE

Caution The risk of drug dependence is high.

hydromorphone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8421F NP	1	..	..	33.36	34.57	Dilaudid-HP [MF]

hydromorphone hydrochloride 2 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8420E NP	1	..	..	28.53	29.74	Dilaudid [MF]

▪ HYDROMORPHONE

Caution The risk of drug dependence is high.

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

hydromorphone hydrochloride 8 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5117H DP	1	..	..	31.37	32.58	Dilaudid [MF]

hydromorphone hydrochloride 4 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5116G DP	1	..	..	22.96	24.17	Dilaudid [MF]

hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5132D DP	1	..	..	69.31	39.50	Dilaudid [MF]

hydromorphone hydrochloride 2 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5115F DP	1	..	..	20.69	21.90	Dilaudid [MF]

▪ HYDROMORPHONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

hydromorphone hydrochloride 8 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8543P NP	1	..	..	31.37	32.58	Dilaudid [MF]

hydromorphone hydrochloride 4 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8542N NP	1	..	..	22.96	24.17	Dilaudid [MF]

hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8424J NP	1	..	..	69.31	39.50	Dilaudid [MF]

hydromorphone hydrochloride 2 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8541M NP	1	..	..	20.69	21.90	Dilaudid [MF]

▪ HYDROMORPHONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

hydromorphone hydrochloride 8 mg modified release tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9406C NP	1	..	..	36.64	37.85	Jurnista [JC]

hydromorphone hydrochloride 64 mg modified release tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9409F NP	1	..	..	135.22	39.50	Jurnista [JC]

hydromorphone hydrochloride 4 mg modified release tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9299K NP	1	..	..	32.12	33.33	Jurnista [JC]

hydromorphone hydrochloride 32 mg modified release tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9408E NP	1	..	..	82.83	39.50	Jurnista [JC]

hydromorphone hydrochloride 16 mg modified release tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9407D NP	1	..	..	51.33	39.50	Jurnista [JC]

▪ MORPHINE

Caution The risk of drug dependence is high.

morphine hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10869C NP	1	..	..	30.23	31.44	Morphine Juno [JU]

morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1647Q NP	1	..	..	23.92	25.13	Hospira Pty Limited [PF]

morphine hydrochloride 20 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10874H NP	1	..	..	23.78	24.99	Morphine Juno [JU]

morphine tartrate 120 mg/1.5 mL injection, 5 x 1.5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1607N NP	1	..	..	42.74	39.50	Hospira Pty Limited [PF]

morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1645N NP MW	1	..	..	21.82	23.03	Hospira Pty Limited [PF]

morphine hydrochloride 100 mg/5 mL injection, 5 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10878M NP	1	..	..	40.98	39.50	Morphine Juno [JU]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5170D DP	1	..	..	23.92	25.13	Hospira Pty Limited [PF]

morphine hydrochloride 20 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10858L DP	1	..	..	23.78	24.99	Morphine Juno [JU]

morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5169C DP	1	..	..	21.82	23.03	Hospira Pty Limited [PF]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the forms morphine sulfate 10 mg/mL injection and morphine hydrochloride 10 mg/mL injection are equivalent for the purposes of substitution.

morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1644M NP MW	1	..	..	20.42	21.63	[a] Hospira Pty Limited [PF]

morphine hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10864T NP MW	1	..	..	20.42	21.63	[a] Morphine Juno [JU]

▪ MORPHINE

Caution The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Clinical criteria:

- The condition must be due to cancer, **AND**
- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 200 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8453X NP	1	..	..	116.58	39.50	MS Contin [MF]

morphine sulfate 200 mg modified release granules, 28 sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8454Y NP	1	..	..	154.66	39.50	MS Contin Suspension 200 mg [MF]

▪ MORPHINE

Caution The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be due to cancer, **AND**
- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 20 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8670H NP	1	..	..	19.43	20.64	Sevredol [MF]

morphine sulfate 10 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8669G NP	1	..	..	18.61	19.82	Sevredol [MF]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

Note Pharmaceutical benefits that have the forms morphine sulfate 10 mg/mL injection and morphine hydrochloride 10 mg/mL injection are equivalent for the purposes of substitution.

morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5168B DP	1	..	..	20.42	21.63	[a] Hospira Pty Limited [PF]

morphine hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10863R DP	1	..	..	20.42	21.63	[a] Morphine Juno [JU]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

morphine hydrochloride 5 mg/mL oral liquid, 200 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2123R NP	1	..	..	25.93	27.14	Ordine 5 [MF]

morphine hydrochloride 10 mg/mL oral liquid, 200 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2124T NP	1	..	..	29.52	30.73	Ordine 10 [MF]

morphine hydrochloride 2 mg/mL oral liquid, 200 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2122Q NP	1	..	..	23.84	25.05	Ordine 2 [MF]

morphine sulfate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1646P NP	1	..	..	18.36	19.57	Anamorph [RW]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 60 mg modified release capsule, 14

8492Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	37.35	38.56	MS Mono [MF]

morphine Sachet containing controlled release granules for oral suspension, 30 mg per sachet, 28

8146R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	62.23	39.50	MS Contin Suspension 30 mg [MF]

morphine sulfate 30 mg modified release tablet, 28

1654C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	37.37	38.58	[a] Momex SR 30 [RW] [a] MORPHINE MR APOTEX [TX] [a] MS Contin [MF]	[a] Morphine MR AN [EA] [a] Morphine MR Mylan [AF]

morphine Sachet containing controlled release granules for oral suspension, 60 mg per sachet, 28

8305D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	69.32	39.50	MS Contin Suspension 60 mg [MF]

morphine sulfate 15 mg modified release tablet, 28

8489T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	27.23	28.44	MS Contin [MF]

morphine sulfate 30 mg modified release capsule, 14

8491X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	27.22	28.43	MS Mono [MF]

morphine Capsule 100 mg (containing sustained release pellets), 28

2841M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	69.86	39.50	Kapanol [YN]

morphine sulfate 10 mg modified release tablet, 28

1653B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	23.59	24.80	[a] Momex SR 10 [RW] [a] MORPHINE MR APOTEX [TX] [a] MS Contin [MF]	[a] Morphine MR AN [EA] [a] Morphine MR Mylan [AF]

morphine Capsule 20 mg (containing sustained release pellets), 28

2839K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	27.91	29.12	Kapanol [YN]

morphine sulfate 100 mg modified release tablet, 28

1656E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	71.72	39.50	[a] Momex SR 100 [RW] [a] MORPHINE MR APOTEX [TX] [a] MS Contin [MF]	[a] Morphine MR AN [EA] [a] Morphine MR Mylan [AF]

morphine sulfate 100 mg modified release granules, 28 sachets

8306E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	84.32	39.50	MS Contin Suspension 100 mg [MF]

morphine sulfate 20 mg modified release granules, 28 sachets

8490W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	60.61	39.50	MS Contin Suspension 20 mg [MF]

morphine Capsule 10 mg (containing sustained release pellets), 28

8349K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	23.58	24.79	Kapanol [YN]

morphine sulfate 60 mg modified release tablet, 28

1655D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	54.95	39.50	[a] Momex SR 60 [RW] [a] MORPHINE MR APOTEX [TX] [a] MS Contin [MF]	[a] Morphine MR AN [EA] [a] Morphine MR Mylan [AF]

morphine sulfate 5 mg modified release tablet, 28

8035X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	21.47	22.68	MS Contin [MF]

morphine sulfate 90 mg modified release capsule, 14

8493B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	42.18	39.50	MS Mono [MF]

morphine Capsule 50 mg (containing sustained release pellets), 28

2840L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	43.82	39.50	Kapanol [YN]

morphine sulfate 120 mg modified release capsule, 14

8494C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	54.94	39.50	MS Mono [MF]

▪ MORPHINE

Caution The risk of drug dependence is high.

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

morphine hydrochloride 5 mg/mL oral liquid, 200 mL

5238Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	25.93	27.14	Ordine 5 [MF]

morphine hydrochloride 10 mg/mL oral liquid, 200 mL

5239R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	29.52	30.73	Ordine 10 [MF]

morphine hydrochloride 2 mg/mL oral liquid, 200 mL

5237P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	23.84	25.05	Ordine 2 [MF]

morphine sulfate 30 mg tablet, 20

5163R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	18.36	19.57	Anamorph [RW]

▪ OXYCODONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

oxycodone hydrochloride 10 mg capsule, 20

8501K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	18.70	19.91	OxyNorm [MF]

oxycodone hydrochloride 5 mg tablet, 20

2622B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	16.42	17.63	[a] Endone [QA]	[a] Mayne Pharma Oxycodone IR [YN]

[a] Oxycodone Aspen [FM]

oxycodone hydrochloride 5 mg capsule, 20

8464L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	16.42	17.63	OxyNorm [MF]

oxycodone hydrochloride 1 mg/mL oral liquid, 250 mL

8644Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	27.34	28.55	OxyNorm Liquid 1mg/mL [MF]

oxycodone 30 mg suppository, 12

2481N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	46.45	39.50	Proladone [PL]

oxycodone hydrochloride 20 mg capsule, 20

8502L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	22.14	23.35	OxyNorm [MF]

▪ OXYCODONE

Caution The risk of drug dependence is high.

Note Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

oxycodone hydrochloride 10 mg capsule, 20

5197M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	18.70	19.91	OxyNorm [MF]

oxycodone hydrochloride 5 mg tablet, 20

5195K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	16.42	17.63	[a] Endone [QA]	[a] Mayne Pharma Oxycodone IR [YN]
						[a] Oxycodone Aspen [FM]	

oxycodone hydrochloride 5 mg capsule, 20

5191F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	16.42	17.63	OxyNorm [MF]

oxycodone hydrochloride 1 mg/mL oral liquid, 250 mL

5190E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	27.34	28.55	OxyNorm Liquid 1mg/mL [MF]

oxycodone 30 mg suppository, 12

5194J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	46.45	39.50	Proladone [PL]

▪ OXYCODONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note OxyContin and Novacodone modified release tablets are intended to be crush-deterrent and to reduce the rapid release of oxycodone upon accidental or intentional misuse.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

oxycodone hydrochloride 40 mg modified release tablet, 28

8387K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	54.94	39.50	[a] Novacodone [HX] [a] OxyContin [MF]	[a] Oxycodone Sandoz [SZ]

oxycodone hydrochloride 20 mg modified release tablet, 28

8386J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	37.36	38.57	[a] Novacodone [HX] [a] OxyContin [MF]	[a] Oxycodone Sandoz [SZ]

oxycodone hydrochloride 80 mg modified release tablet, 28

8388L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	80.99	39.50	[a] Novacodone [HX] [a] OxyContin [MF]	[a] Oxycodone Sandoz [SZ]

oxycodone hydrochloride 10 mg modified release tablet, 28

8385H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	27.23	28.44	[a] Novacodone [HX] [a] OxyContin [MF]	[a] Oxycodone Sandoz [SZ]

▪ OXYCODONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note OxyContin modified release tablets are intended to be crush-deterrent and to reduce the rapid release of oxycodone upon accidental or intentional misuse.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

oxycodone hydrochloride 30 mg modified release tablet, 28

9400R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	46.92	39.50	OxyContin [MF]

oxycodone hydrochloride 15 mg modified release tablet, 28

9399Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	33.34	34.55	OxyContin [MF]

▪ OXYCODONE + NALOXONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

oxycodone hydrochloride 10 mg + naloxone hydrochloride 5 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8934F NP	1	..	..	32.83	34.04	Targin 10/5mg [MF]

oxycodone hydrochloride 40 mg + naloxone hydrochloride 20 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8936H NP	1	..	..	72.42	39.50	Targin 40/20mg [MF]

oxycodone hydrochloride 2.5 mg + naloxone hydrochloride 1.25 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10776E NP	1	..	..	23.96	25.17	Targin 2.5/1.25 mg [MF]

oxycodone hydrochloride 20 mg + naloxone hydrochloride 10 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8935G NP	1	..	..	47.32	39.50	Targin 20/10mg [MF]

oxycodone hydrochloride 80 mg + naloxone hydrochloride 40 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11111T NP	1	..	..	94.36	39.50	Targin 80/40 [MF]

oxycodone hydrochloride 5 mg + naloxone hydrochloride 2.5 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8000C NP	1	..	..	31.70	32.91	Targin 5/2.5mg [MF]

oxycodone hydrochloride 30 mg + naloxone hydrochloride 15 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10758F NP	1	..	..	53.47	39.50	Targin 30/15 mg [MF]

oxycodone hydrochloride 60 mg + naloxone hydrochloride 30 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11102H NP	1	..	..	79.72	39.50	Targin 60/30 [MF]

oxycodone hydrochloride 15 mg + naloxone hydrochloride 7.5 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10757E NP	1	..	..	37.18	38.39	Targin 15/7.5mg [MF]

Phenylpiperidine derivatives

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the form fentanyl 12 microgram/hour patch are equivalent for the purposes of substitution.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

fentanyl 12 microgram/hour patch, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5265D NP	1	..	..	22.56	23.77	[a] Denpax [AF]

fentanyl 12 microgram/hour patch, 5

5437E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	22.56	23.77	[a] Dutran 12 [EA]	[a] Fenpatch 12 [ZP]

fentanyl 12 microgram/hour patch, 5

8878G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	22.56	23.77	[a] APO-Fentanyl [TX] [a] Fentanyl Sandoz [SZ]	[a] Durogesic 12 [JC]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the form fentanyl 25 microgram/hour patch are equivalent for the purposes of substitution.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

fentanyl 25 microgram/hour patch, 5

5277R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	24.86	26.07	[a] Denpax [AF]

fentanyl 25 microgram/hour patch, 5

5438F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	24.86	26.07	[a] Dutran 25 [EA]	[a] Fenpatch 25 [ZP]

fentanyl 25 microgram/hour patch, 5

8891Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	24.86	26.07	[a] APO-Fentanyl [TX] [a] Fentanyl Sandoz [SZ]	[a] Durogesic 25 [JC]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the form fentanyl 50 microgram/hour patch are equivalent for the purposes of substitution.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

fentanyl 50 microgram/hour patch, 5

5278T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	33.88	35.09	[a] Denpax [AF]

fentanyl 50 microgram/hour patch, 5

5439G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	33.88	35.09	[a] Dutran 50 [EA]	[a] Fenpatch 50 [ZP]

fentanyl 50 microgram/hour patch, 5

8892B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	33.88	35.09	[a] APO-Fentanyl [TX] [a] Fentanyl Sandoz [SZ]	[a] Durogesic 50 [JC]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the form fentanyl 75 microgram/hour patch are equivalent for the purposes of substitution.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

fentanyl 75 microgram/hour patch, 5

5279W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	41.21	39.50	[a] Denpax [AF]

fentanyl 75 microgram/hour patch, 5

5440H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	41.21	39.50	[a] Dutran 75 [EA]	[a] Fenpatch 75 [ZP]

fentanyl 75 microgram/hour patch, 5

8893C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	41.21	39.50	[a] APO-Fentanyl [TX] [a] Fentanyl Sandoz [SZ]	[a] Durogesic 75 [JC]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Pharmaceutical benefits that have the form fentanyl 100 microgram/hour patch are equivalent for the purposes of substitution.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

fentanyl 100 microgram/hour patch, 5

5280X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	47.73	39.50	[a] Denpax [AF]

fentanyl 100 microgram/hour patch, 5

5441J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	47.73	39.50	[a] Dutran 100 [EA]	[a] Fenpatch 100 [ZP]

fentanyl 100 microgram/hour patch, 5

8894D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	47.73	39.50	[a] APO-Fentanyl [TX] [a] Fentanyl Sandoz [SZ]	[a] Durogesic 100 [JC]

Diphenylpropylamine derivatives

▪ METHADONE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

methadone hydrochloride 10 mg tablet, 20

1609Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	19.40	20.61	Physeptone [QA]

methadone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

1606M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	49.78	39.50	Physeptone [QA]

Oripavine derivatives

▪ BUPRENORPHINE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

buprenorphine 15 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10770W NP	1	..	..	47.33	39.50	Norspan [MF]

buprenorphine 20 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8867Q NP	1	..	..	54.43	39.50	Norspan [MF]

buprenorphine 30 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10755C NP	1	..	..	67.87	39.50	Norspan [MF]

buprenorphine 10 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8866P NP	1	..	..	40.24	39.50	Norspan [MF]

buprenorphine 25 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10756D NP	1	..	..	61.15	39.50	Norspan [MF]

buprenorphine 40 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10746N NP	1	..	..	81.31	39.50	Norspan [MF]

buprenorphine 5 microgram/hour patch, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8865N NP	1	..	..	28.62	29.83	Norspan [MF]

Opioids in combination with non-opioid analgesics

▪ PARACETAMOL + CODEINE

paracetamol 500 mg + codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3316M DP	1	..	..	12.44	13.65	[a] APO- Paracetamol/Codeine 500/30 [TX] [a] Codapane Forte 500/30 [AL] [a] Paracetamol/Codeine GH 500/30 [GQ]	[a] Codalgin Forte [FM] [a] Comfarol Forte [SZ] [a] Prodeine Forte [AV]
			[B]2.10	14.54	13.65	[a] Panadeine Forte [SW]	

▪ PARACETAMOL + CODEINE

Note Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of codeine phosphate with paracetamol.

paracetamol 500 mg + codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1215Y NP	1	..	..	12.44	13.65	[a] APO- Paracetamol/Codeine 500/30 [TX] [a] Codapane Forte 500/30 [AL] [a] Paracetamol/Codeine GH 500/30 [GQ]	[a] Codalgin Forte [FM] [a] Comfarol Forte [SZ] [a] Prodeine Forte [AV]
			[B]2.10	14.54	13.65	[a] Panadeine Forte [SW]	

▪ PARACETAMOL + CODEINE

Note Each authority approval will be limited to no more than 240 tablets per month for no more than 6 months.

Authority required

Severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

paracetamol 500 mg + codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8785J NP	3	..	..	*15.13	16.34	[a] APO- Paracetamol/Codeine 500/30 [TX] [a] Codapane Forte 500/30 [AL] [a] Paracetamol/Codeine GH 500/30 [GQ]	[a] Codalgin Forte [FM] [a] Comfarol Forte [SZ] [a] Prodeine Forte [AV]

[B]6.30	*21.43	16.34	[a] Panadeine Forte [SW]	

Other opioids

▪ TAPENTADOL

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain not responding to non-opioid analgesics where the total duration of opioid analgesic treatment is less than 12 months; or
(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-opioid analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing opioid analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or
(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-opioid analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

tapentadol 50 mg modified release tablet, 28

10096J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	25.52	26.73	Palexia SR [CS]

tapentadol 150 mg modified release tablet, 28

10100N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	40.95	39.50	Palexia SR [CS]

tapentadol 200 mg modified release tablet, 28

10091D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	47.62	39.50	Palexia SR [CS]

tapentadol 100 mg modified release tablet, 28

10094G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	33.39	34.60	Palexia SR [CS]

tapentadol 250 mg modified release tablet, 28

10092E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	53.28	39.50	Palexia SR [CS]

▪ TRAMADOL

Restricted benefit

Pain

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

tramadol hydrochloride 100 mg/mL oral liquid, 10 mL

5150C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	17.43	18.64	Tramal [CS]

▪ TRAMADOL

Restricted benefit

Acute pain

Clinical criteria:

- The treatment must be for the short-term.

tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules

5231H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.94	15.15	[a] Tramadol ACT [EA] [a] Tramal 100 [CS]	[a] Tramadol Sandoz [SZ]

▪ TRAMADOL

Note Authorities for increased maximum quantities and/or repeats will be granted only for severe disabling pain not responding to non-opioid analgesics.

Restricted benefit

Pain

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

tramadol hydrochloride 100 mg/mL oral liquid, 10 mL

8843K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	17.43	18.64	Tramal [CS]

tramadol hydrochloride 150 mg modified release tablet, 20

8524P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.32	15.53	[a] APO-Tramadol SR [TX]	[a] Chem mart Tramadol SR [CH]
						[a] Lodam SR 150 [ZP]	[a] Terry White Chemists Tramadol SR [TW]
						[a] Tramadol AN SR [EA]	[a] Tramadol Sandoz SR [SZ]
						[a] Tramadol SR generichealth [GQ]	[a] Tramedo SR 150 [AF]
						[a] Zydol SR 150 [RW]	
			[B]5.37	19.69	15.53	[a] Tramal SR 150 [CS]	

tramadol hydrochloride 200 mg modified release tablet, 20

8525Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.03	16.24	[a] APO-Tramadol SR [TX]	[a] Chem mart Tramadol SR [CH]
						[a] Terry White Chemists Tramadol SR [TW]	[a] Tramadol AN SR [EA]
						[a] Tramadol Sandoz SR [SZ]	[a] Tramadol SR generichealth [GQ]
						[a] Tramedo SR 200 [AF]	[a] Zydol SR 200 [RW]
			[B]6.08	21.11	16.24	[a] Tramal SR 200 [CS]	

tramadol hydrochloride 50 mg modified release tablet, 20

2527B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	14.24	15.45	Tramal SR 50 [CS]

tramadol hydrochloride 100 mg modified release tablet, 20

8523N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.50	14.71	[a] APO-Tramadol SR [TX]	[a] Chem mart Tramadol SR [CH]
						[a] Lodam SR 100 [ZP]	[a] Terry White Chemists Tramadol SR [TW]
						[a] Tramadol AN SR [EA]	[a] Tramadol Sandoz SR [SZ]
						[a] Tramadol SR generichealth [GQ]	[a] Tramedo SR 100 [AF]
						[a] Zydol SR 100 [RW]	
			[B]4.49	17.99	14.71	[a] Tramal SR 100 [CS]	

▪ TRAMADOL

Restricted benefit

Acute pain

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

Restricted benefit

Chronic pain

Treatment Phase: Dose titration

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

tramadol hydrochloride 50 mg capsule, 20

5232J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.09	14.30	[a] APO-Tramadol [TX]	[a] Chem mart Tramadol [CH]
						[a] Terry White Chemists Tramadol [TW]	[a] Tramadol AMNEAL [EF]
						[a] Tramadol AN [EA]	[a] Tramadol Sandoz [SZ]
						[a] Tramadol SCP [CR]	[a] Tramedo [AF]
						[a] Zydol [RW]	
			[B]2.42	15.51	14.30	[a] Tramal [CS]	

▪ TRAMADOL

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Acute pain

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

tramadol hydrochloride 50 mg capsule, 20

8455B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.09	14.30	[a] APO-Tramadol [TX] [a] Terry White Chemists Tramadol [TW] [a] Tramadol AN [EA] [a] Tramadol SCP [CR] [a] Zydol [RW]	[a] Chem mart Tramadol [CH] [a] Tramadol AMNEAL [EF] [a] Tramadol Sandoz [SZ] [a] Tramedo [AF]
			[B]2.42	15.51	14.30	[a] Tramal [CS]	

▪ TRAMADOL

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Acute pain

Clinical criteria:

- The treatment must be for the short-term.

tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules

8582Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.94	15.15	[a] Tramadol ACT [EA] [a] Tramal 100 [CS]	[a] Tramadol Sandoz [SZ]

▪ TRAMADOL

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Chronic pain

Treatment Phase: Dose titration

Clinical criteria:

- The condition must be one in which aspirin and/or paracetamol alone are inappropriate or have failed.

tramadol hydrochloride 50 mg capsule, 20

8611F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.09	14.30	[a] APO-Tramadol [TX] [a] Terry White Chemists Tramadol [TW] [a] Tramadol AN [EA] [a] Tramadol SCP [CR] [a] Zydol [RW]	[a] Chem mart Tramadol [CH] [a] Tramadol AMNEAL [EF] [a] Tramadol Sandoz [SZ] [a] Tramedo [AF]
			[B]2.42	15.51	14.30	[a] Tramal [CS]	

OTHER ANALGESICS AND ANTIPYRETICS

Salicylic acid and derivatives

▪ ASPIRIN

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

aspirin 300 mg effervescent tablet, 96

1010E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	12.61	13.82	Solprin [RC]

▪ ASPIRIN

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

aspirin 300 mg effervescent tablet, 96

5018D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	12.61	13.82	Solprin [RC]

Anilides

▪ PARACETAMOL

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

paracetamol 240 mg/5 mL oral liquid, 200 mL

1770E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	14.79	16.00	Panamax 240 Elixir [SW]

paracetamol 120 mg/5 mL oral liquid, 100 mL

1747Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	13.66	14.87	Panamax [SW]

paracetamol 500 mg tablet, 100

1746X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	12.74	13.95	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

▪ PARACETAMOL

Restricted benefit

For treatment of a patient identifying as Aboriginal or Torres Strait Islander

paracetamol 240 mg/5 mL oral liquid, 200 mL

3349G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	14.79	16.00	Panamax 240 Elixir [SW]

paracetamol 120 mg/5 mL oral liquid, 100 mL

3348F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	13.66	14.87	Panamax [SW]

paracetamol 500 mg tablet, 100

5196L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.74	13.95	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

▪ PARACETAMOL

Restricted benefit

Chronic arthropathies

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

paracetamol 500 mg tablet, 100

5224Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	3	..	..	*16.03	17.24	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

▪ PARACETAMOL

Restricted benefit

Chronic arthropathies

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

paracetamol 500 mg tablet, 100

8784H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	4	..	*16.03	17.24	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

▪ PARACETAMOL

Note Pharmaceutical benefits that have the form paracetamol 665 mg tablet: modified release, 96 and pharmaceutical benefits that have the form paracetamol 665 mg tablet: modified release, 192 are equivalent for the purposes of substitution.

Restricted benefit

Persistent pain

Clinical criteria:

- The condition must be associated with osteoarthritis.

Population criteria:

- Patient must identify as Aboriginal or Torres Strait Islander.

paracetamol 665 mg tablet: modified release, 192

10797G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.55	19.76	[a] Osteomol 665 Paracetamol [CR]

paracetamol 665 mg modified release tablet, 96

8814X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*18.55	19.76	[a] APOHEALTH Osteo Relief Paracetamol 665 mg [TX]	[a] Osteomol 665 Paracetamol [CR]

Other analgesics and antipyretics

▪ PREGABALIN

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4172

Neuropathic pain

Clinical criteria:

- The condition must be refractory to treatment with other drugs.

pregabalin 150 mg capsule, 56

2355Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	54.98	39.50	[a] APO-Pregabalin [TX]	[a] Blooms The Chemist Pregabalin [IB]
						[a] LYPRALIN [RW]	[a] Lyrica [PF]
						[a] Lyzalon [AF]	[a] Neuroccord [CR]
						[a] Pregabalin AMNEAL [EA]	[a] Pregabalin APOTEX [GX]
						[a] PREGABALIN-DRLA [RZ]	[a] Pregabalin GH [GQ]
						[a] Pregabalin Sandoz [SZ]	[a] Pregabalin-Teva [TB]

pregabalin 75 mg capsule, 56

2335X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	39.70	39.50	[a] APO-Pregabalin [TX]	[a] Blooms The Chemist Pregabalin [IB]
						[a] LYPRALIN [RW]	[a] Lyrica [PF]
						[a] Lyzalon [AF]	[a] Neuroccord [CR]
						[a] Pregabalin AMNEAL [EA]	[a] Pregabalin APOTEX [GX]
						[a] PREGABALIN-DRLA [RZ]	[a] Pregabalin GH [GQ]
						[a] Pregabalin Sandoz [SZ]	[a] Pregabalin-Teva [TB]

pregabalin 300 mg capsule, 56

2363J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	76.58	39.50	[a] APO-Pregabalin [TX]	[a] Blooms The Chemist Pregabalin [IB]
						[a] LYPRALIN [RW]	[a] Lyrica [PF]
						[a] Lyzalon [AF]	[a] Neuroccord [CR]
						[a] Pregabalin AMNEAL [EA]	[a] Pregabalin APOTEX [GX]
						[a] PREGABALIN-DRLA [RZ]	[a] Pregabalin GH [GQ]
						[a] Pregabalin Sandoz [SZ]	[a] Pregabalin-Teva [TB]

pregabalin 25 mg capsule, 56

2348N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	24.02	25.23	[a] APO-Pregabalin [TX]	[a] Blooms The Chemist Pregabalin [IB]
						[a] LYPRALIN [RW]	[a] Lyrica [PF]
						[a] Lyzalon [AF]	[a] Neuroccord [CR]
						[a] Pregabalin AMNEAL [EA]	[a] Pregabalin APOTEX [GX]
						[a] PREGABALIN-DRLA [RZ]	[a] Pregabalin GH [GQ]
						[a] Pregabalin Sandoz [SZ]	[a] Pregabalin-Teva [TB]

ANTIMIGRAINE PREPARATIONS

Selective serotonin (5HT1) agonists

▪ ELETRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past.

eletriptan 80 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5291L NP	1	5	..	26.24	27.45	Relpax [PF]

eletriptan 40 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5290K NP	1	5	..	26.24	27.45	Relpax [PF]

▪ NARATRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past.

naratriptan 2.5 mg tablet, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8298R NP	2	5	^{S}2.28	*29.47	28.40	Naramig [AS]

▪ NARATRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past, **AND**
- Patient must be one in whom adverse events have occurred with other suitable PBS-listed drugs.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past, **AND**
- Patient must be one in whom drug interactions have occurred with other suitable PBS-listed drugs.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past, **AND**
- Patient must be one in whom drug interactions are expected to occur with other suitable PBS-listed drugs.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past, **AND**
- Patient must be one in whom transfer to another suitable PBS-listed drug would cause patient confusion resulting in problems with compliance.

Authority required

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past, **AND**
- Patient must be one in whom transfer to another suitable PBS-listed drug is likely to result in adverse clinical consequences.

naratriptan 2.5 mg tablet, 2

9734H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*29.47	30.68	Naramig [AS]

▪ RIZATRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note Pharmaceutical benefits that have the form rizatriptan wafer 10 mg (as benzoate) and pharmaceutical benefits that have the form rizatriptan tablet (orally disintegrating) 10 mg (as benzoate) are equivalent for the purposes of substitution.

Restricted benefit

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past.

rizatriptan 10 mg orally disintegrating tablet, 2

10551H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*20.91	22.12	[a] APO-Rizatriptan [TX] [a] MAXATAN [RW] [a] Rizatriptan ODT GH [GQ]	[a] Chem mart Rizatriptan [CH] [a] Rizatriptan AN ODT [EA] [a] Terry White Chemists Rizatriptan [TW]

rizatriptan 10 mg wafer, 2

9313E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*20.91	22.12	[a] Maxalt [AL]	[a] Rizatriptan Wafers-10mg [AF]

▪ SUMATRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Pharmaceutical benefits that have the form sumatriptan tablet 50 mg (as succinate) and pharmaceutical benefits that have the form sumatriptan tablet (fast disintegrating) 50 mg (as succinate) are equivalent for the purposes of substitution.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Migraine attack

Clinical criteria:

- The condition must have usually failed to respond to analgesics in the past.

SUMATRIPTAN Tablet 50 mg (as succinate), 2

8144P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*16.25	17.46	[a] APO-Sumatriptan [TX] [a] Iptam [AL] [a] Sumatriptan Sandoz [SZ]	[a] Chem mart Sumatriptan [CH] [a] Sumatran [OW] [a] Terry White Chemists Sumatriptan [TW]
			[B]4.20	*20.45	17.46	[a] Imigran [LN]	

sumatriptan 20 mg/actuation nasal spray, 2 x 1 actuation

8341B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	22.25	23.46	Imigran [AS]

SUMATRIPTAN Tablet (fast disintegrating) 50 mg (as succinate), 2

8885P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	[B]4.20	*20.45	17.46	[a] Imigran FDT [AS]

sumatriptan 50 mg tablet, 4

1849H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.25	17.46	[a] APO-Sumatriptan [TX]	[a] Chem mart Sumatriptan [CH]
						[a] Iptam [AL]	[a] Pharmacor Sumatriptan 50 [CR]
						[a] Sumatran [OW]	[a] Sumatriptan AN [EA]
						[a] Sumatriptan generichealth [GQ]	[a] Sumatriptan RBX [RA]
						[a] Sumatriptan Sandoz [SZ]	[a] Terry White Chemists Sumatriptan [TW]
			[B]4.19	20.44	17.46	[a] Imigran [LN]	

SUMATRIPTAN Tablet 50 mg (base) (fast disintegrating), 4

10694W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	[B]4.19	20.44	17.46	[a] Imigran FDT [AS]

▪ ZOLMITRIPTAN

Caution Selective serotonin (5HT1) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Migraine attack
Clinical criteria:
- The condition must have usually failed to respond to analgesics in the past.

zolmitriptan 2.5 mg tablet, 2

8266C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*22.97	24.18	[a] APO-Zolmitriptan [TX]	[a] Zoltrip [RW]
			[B]2.76	*25.73	24.18	[a] Zomig [AP]	

Other antimigraine preparations

▪ PIZOTIFEN

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pizotifen 500 microgram tablet, 100

3074T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	24.67	25.88	Sandomigran 0.5 [AE]

▪ ANTIEPILEPTICS

ANTIEPILEPTICS

Barbiturates and derivatives

▪ PHENOBARBITAL (PHENOBARBITONE)

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Epilepsy

phenobarbital (phenobarbitone) 30 mg tablet, 200

1850J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	4	..	19.50	20.71	Phenobarb [RW]

phenobarbital (phenobarbitone) sodium 219 mg/mL injection, 5 x 1 mL ampoules

2138M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	38.02	39.23	Fawns and McAllan Proprietary Limited [FM]

▪ PRIMIDONE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

primidone 250 mg tablet, 200

1939C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	77.64	39.50	Mysoline [LM]

Hydantoin derivatives

▪ PHENYTOIN

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

phenytoin sodium 30 mg capsule, 200

1873N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	31.08	32.29	Dilantin Sodium [PF]

phenytoin sodium 100 mg capsule, 200

1874P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	34.85	36.06	Dilantin Sodium [PF]

phenytoin 50 mg chewable tablet, 200

1249R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	48.49	39.50	Dilantin Infatabs [PF]

phenytoin 30 mg/5 mL oral liquid, 500 mL

2692Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	3	..	30.81	32.02	Dilantin [PF]

Succinimide derivatives

▪ ETHOSUXIMIDE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ethosuximide 250 mg/5 mL oral liquid, 200 mL

1414K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	71.68	39.50	Zarontin [IX]

ethosuximide 250 mg capsule, 200

1413J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	318.33	39.50	Zarontin [IX]

Benzodiazepine derivatives

▪ CLONAZEPAM

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Epilepsy

clonazepam 1 mg/mL injection [5 x 1 mL ampoules] (&) inert substance diluent [5 x 1 mL ampoules], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1807D NP	1	..	..	21.66	22.87	Rivotril [RO]

▪ CLONAZEPAM

Caution Abuse of clonazepam has been reported. Refer to the current product information.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required
Epilepsy
Clinical criteria:
- The condition must be neurologically proven.

clonazepam 500 microgram tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1805B NP	2	2	..	*22.47	23.68	[a] Paxam 0.5 [AF]
			[B]3.68	*26.15	23.68	[a] Rivotril [RO]

clonazepam 2.5 mg/mL oral liquid, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1808E NP	2	..	..	*18.59	19.80	Rivotril [RO]

clonazepam 2 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1806C NP	2	2	..	*32.51	33.72	[a] Paxam 2 [AF]
			[B]4.60	*37.11	33.72	[a] Rivotril [RO]

▪ NITRAZEPAM

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required
Myoclonic epilepsy
Authority required
Malignant neoplasia (late stage)
Authority required
Insomnia
Clinical criteria:
- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

Authority required
Insomnia
Clinical criteria:
- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care, **AND**
- Patient must be one in respect of whom a Carer Allowance is payable as a disabled adult, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

nitrazepam 5 mg tablet, 25

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2732T NP	2	5	..	*14.31	15.52	[a] Alodorm [AF]
			[B]2.48	*16.79	15.52	[a] Mogadon [IA]

Carboxamide derivatives

▪ CARBAMAZEPINE

CARBAMAZEPINE Tablet 100 mg, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5039F DP	2	..	..	*22.85	24.06	[a] Carbamazepine Sandoz [SZ]
			[B]3.00	*25.85	24.06	[a] Tegretol 100 [NV]

carbamazepine 400 mg modified release tablet, 200

5037D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	49.20	39.50	Tegretol CR 400 [NV]

CARBAMAZEPINE Tablet 200 mg, 100

1724R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	2	..	..	*30.73	31.94	[a] Carbamazepine Sandoz [SZ]
			[B]2.96	*33.69	31.94	[a] Tegretol 200 [NV]

carbamazepine 200 mg modified release tablet, 200

5038E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	31.14	32.35	Tegretol CR 200 [NV]

carbamazepine 100 mg/5 mL oral liquid, 300 mL

5041H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	‡1	..	..	24.07	25.28	Tegretol Liquid [NV]

▪ CARBAMAZEPINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CARBAMAZEPINE Tablet 100 mg, 100

2422L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*22.85	24.06	[a] Carbamazepine Sandoz [SZ]
			[B]3.00	*25.85	24.06	[a] Tegretol 100 [NV]

carbamazepine 400 mg modified release tablet, 200

2431Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	49.20	39.50	Tegretol CR 400 [NV]

CARBAMAZEPINE Tablet 200 mg, 100

1706T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*30.73	31.94	[a] Carbamazepine Sandoz [SZ]
			[B]2.96	*33.69	31.94	[a] Tegretol 200 [NV]

carbamazepine 200 mg modified release tablet, 200

2426Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	31.14	32.35	Tegretol CR 200 [NV]

carbamazepine 100 mg/5 mL oral liquid, 300 mL

2427R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	24.07	25.28	Tegretol Liquid [NV]

▪ OXCARBAZEPINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5183

Seizures

Clinical criteria:

- Patient must have partial epileptic seizures; OR
- Patient must have primary generalised tonic-clonic seizures, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

oxcarbazepine 300 mg tablet, 100

8585W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	104.93	39.50	Trileptal [NV]

oxcarbazepine 60 mg/mL oral liquid, 250 mL

8588B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*124.83	39.50	Trileptal [NV]

oxcarbazepine 600 mg tablet, 100

8586X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	167.89	39.50	Trileptal [NV]

oxcarbazepine 150 mg tablet, 100

8584T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	67.96	39.50	Trileptal [NV]

Fatty acid derivatives

▪ TIAGABINE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4928
Partial epileptic seizures
Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

tiagabine 15 mg tablet, 50

8223T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*175.57	39.50	Gabitril [OA]

tiagabine 5 mg tablet, 50

8221Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*68.27	39.50	Gabitril [OA]

tiagabine 10 mg tablet, 50

8222R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*125.45	39.50	Gabitril [OA]

▪ VALPROATE

Caution There are reports of fatal hepatotoxicity, particularly in children.
There is increasing evidence of dose-related teratogenesis from this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

valproate sodium 100 mg tablet, 100

2294R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*33.33	34.54	Epilim [SW]

valproate sodium 200 mg/5 mL oral liquid, 300 mL

2293Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*39.05	39.50	Epilim Liquid [SW]

valproate sodium 200 mg/5 mL oral liquid, 300 mL

2295T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*39.05	39.50	Epilim Syrup [SW]

valproate sodium 200 mg enteric tablet, 100

2289L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*22.83	24.04	[a] Sodium Valproate Sandoz [SZ] [a] Valproate Winthrop EC 200 [WA]	[a] Valprease 200 [RW] [a] Valpro EC 200 [AF]
			[B]2.00	*24.83	24.04	[a] Epilim EC [SW]	

valproate sodium 500 mg enteric tablet, 100

2290M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*34.33	35.54	[a] Sodium Valproate Sandoz [SZ] [a] Valproate Winthrop EC 500 [WA]	[a] Valprease 500 [RW] [a] Valpro EC 500 [AF]
			[B]2.00	*36.33	35.54	[a] Epilim EC [SW]	

▪ VIGABATRIN

Caution Visual field defects have been reported with this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4929
Epileptic seizures
Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

vigabatrin 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2667J NP	1	5	..	108.13	39.50	Sabril [SW]

vigabatrin 500 mg powder for oral liquid, 60 sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2668K NP	1	5	..	73.90	39.50	Sabril [SW]

Other antiepileptics

▪ GABAPENTIN

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4928
Partial epileptic seizures
Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

gabapentin 100 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8505P NP	1	5	..	15.13	16.34	[a] APO-Gabapentin [TX] [a] Gabapentin Aspen 100 [RW] [a] Neurontin [PF]	[a] Gabacor [CR] [a] GAPENTIN [RF] [a] Nupentin 100 [AF]

gabapentin 300 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1834M NP	1	5	..	24.59	25.80	[a] APO-Gabapentin [TX] [a] Gabapentin AN [EA] [a] Gabapentin GH [GQ] [a] GAPENTIN [RF] [a] Neurontin [PF]	[a] Gabacor [CR] [a] Gabapentin Aspen 300 [RW] [a] Gabapentin Sandoz [SZ] [a] GenRx Gabapentin [GX] [a] Nupentin 300 [AF]

gabapentin 600 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8559L NP	1	5	..	40.31	39.50	[a] APO-Gabapentin [TX] [a] Gabapentin Aspen 600 [RW] [a] GenRx Gabapentin [GX] [a] Nupentin Tabs [AF]	[a] Gabapentin AN [EA] [a] GAPENTIN [RF] [a] Neurontin [PF] [a] Pharmacor Gabapentin 600 [CR]

gabapentin 400 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1835N NP	1	5	..	29.50	30.71	[a] APO-Gabapentin [TX] [a] Gabapentin AN [EA] [a] Gabapentin GH [GQ] [a] GAPENTIN [RF] [a] Neurontin [PF]	[a] Gabacor [CR] [a] Gabapentin Aspen 400 [RW] [a] Gabapentin Sandoz [SZ] [a] GenRx Gabapentin [GX] [a] Nupentin 400 [AF]

gabapentin 800 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8389M NP	1	5	..	50.06	39.50	[a] APO-Gabapentin [TX] [a] Gabapentin Aspen 800 [RW] [a] GenRx Gabapentin [GX]	[a] Gabapentin AN [EA] [a] GAPENTIN [RF] [a] Neurontin [PF]

	[a] Nupentin Tabs [AF]	[a] Pharmacor Gabapentin 800 [CR]

▪ LACOSAMIDE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4271

Intractable partial epileptic seizures

Treatment Phase: Initial

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents, **AND**
- The treatment must be for dose titration purposes.

Population criteria:

- Patient must be aged 16 years or older.

lacosamide 50 mg tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9333F NP	1	1	..	30.74	31.95	Vimpat [UC]

lacosamide 150 mg tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9336J NP	1	1	..	70.04	39.50	Vimpat [UC]

lacosamide 100 mg tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9334G NP	1	1	..	50.40	39.50	Vimpat [UC]

▪ LACOSAMIDE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4249

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously been treated with PBS-subsidised lacosamide.

Population criteria:

- Patient must be aged 16 years or older.

lacosamide 50 mg tablet, 14

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10293R NP	4	5	..	*89.71	39.50	Vimpat [UC]

▪ LACOSAMIDE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4264

Intractable partial epileptic seizures

Treatment Phase: Initial

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Population criteria:

- Patient must be aged 16 years or older.

Authority required (STREAMLINED)

4249

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously been treated with PBS-subsidised lacosamide.

Population criteria:

- Patient must be aged 16 years or older.

lacosamide 100 mg tablet, 56

9335H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	168.33	39.50	Vimpat [UC]

▪ LACOSAMIDE

Note No applications for increased maximum quantities will be authorised for the 56 tablet packs of the 150 mg and 200 mg strengths.

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4240

Intractable partial epileptic seizures

Treatment Phase: Initial

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Population criteria:

- Patient must be aged 16 years or older.

Authority required (STREAMLINED)

4257

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously been treated with PBS-subsidised lacosamide.

Population criteria:

- Patient must be aged 16 years or older.

lacosamide 150 mg tablet, 56

9337K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	248.85	39.50	Vimpat [UC]

lacosamide 200 mg tablet, 56

9338L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	330.20	39.50	Vimpat [UC]

▪ LAMOTRIGINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5138

Epileptic seizures

Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

lamotrigine 200 mg tablet, 56

2851C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	37.06	38.27	[a] APO-Lamotrigine [TX] [a] Lamotrigine AN [EA] [a] Lamotrigine generichealth [HQ] [a] Lamotrigine Sandoz [SZ] [a] Reedos 200 [DO]	[a] LAMITAN [RF] [a] Lamotrigine Aspen 200 [RW] [a] Lamotrigine GH [GQ] [a] Logem [AL]
			[B]1.49	38.55	38.27	[a] Lamictal [AS]	

lamotrigine 50 mg tablet, 56

2849Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.37	21.58	[a] APO-Lamotrigine [TX] [a] Lamotrigine AN [EA] [a] Lamotrigine GH [GQ] [a] Logem [AL] [a] Sandoz Lamotrigine [HX]	[a] LAMITAN [RF] [a] Lamotrigine Aspen 50 [RW] [a] Lamotrigine Sandoz [SZ] [a] Reedos 50 [DO]
			[B]1.44	21.81	21.58	[a] Lamictal [AS]	

lamotrigine 25 mg tablet, 56

2848X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.66	17.87	[a] APO-Lamotrigine [TX] [a] Lamotrigine AN [EA] [a] Lamotrigine GH [GQ] [a] Logem [AL] [a] Sandoz Lamotrigine [HX]	[a] LAMITAN [RF] [a] Lamotrigine Aspen 25 [RW] [a] Lamotrigine Sandoz [SZ] [a] Reedos 25 [DO]
			[B]1.61	18.27	17.87	[a] Lamictal [AS]	

lamotrigine 100 mg tablet, 56

2850B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.54	27.75	[a] APO-Lamotrigine [TX] [a] Lamotrigine AN [EA] [a] Lamotrigine generichealth [HQ] [a] Lamotrigine Sandoz [SZ] [a] Reedos 100 [DO]	[a] LAMITAN [RF] [a] Lamotrigine Aspen 100 [RW] [a] Lamotrigine GH [GQ] [a] Logem [AL]
			[B]1.51	28.05	27.75	[a] Lamictal [AS]	

lamotrigine 5 mg tablet, 56

8063J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.41	18.62	[a] Lamictal [AS]	[a] Lamotrigine Aspen 5 [RW]

▪ LEVETIRACETAM

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4928

Partial epileptic seizures

Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

levetiracetam 1 g tablet, 60

8656N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	43.09	39.50	[a] APO-Levetiracetam [TX] [a] Kerron 1000 [DO] [a] Levactam [ER] [a] Levetiracetam AN [EA] [a] Levetiracetam SZ [SZ] [a] Levitaccord [RA]	[a] Keppra [UC] [a] Kevtam 1000 [AF] [a] Levecetam 1000 [RZ] [a] Levetiracetam GH [GQ] [a] Levi 1000 [RW]

levetiracetam 250 mg tablet, 60

8654L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.62	23.83	[a] APO-Levetiracetam [TX] [a] Kerron 250 [DO] [a] Levactam [ER] [a] Levetiracetam AN [EA]	[a] Keppra [UC] [a] Kevtam 250 [AF] [a] Levecetam 250 [RZ] [a] Levetiracetam GH [GQ]

						[a] Levetiracetam SZ [SZ]	[a] Levi 250 [RW]

levetiracetam 500 mg tablet, 60

8655M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	30.29	31.50	[a] APO-Levetiracetam [TX] [a] Kerron 500 [DO] [a] Levactam [ER] [a] Levetiracetam AN [EA] [a] Levetiracetam SZ [SZ]	[a] Keppra [UC] [a] Kevtam 500 [AF] [a] Levecetam 500 [RZ] [a] Levetiracetam GH [GQ] [a] Levi 500 [RW]

▪ LEVETIRACETAM

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5215

Partial epileptic seizures

Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, **AND**
- Patient must be unable to take a solid dose form of levetiracetam.

levetiracetam 100 mg/mL oral liquid, 300 mL

9169N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	73.45	39.50	[a] APO-Levetiracetam [TX] [a] Kerron [DO]	[a] Keppra [UC] [a] Levetiracetam-AFT [AE]

▪ PERAMPANEL

Authority required (STREAMLINED)

4656

Intractable partial epileptic seizures

Treatment Phase: Initial

Clinical criteria:

- The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Treatment criteria:

- Must be treated by a neurologist.

perampanel 2 mg tablet, 7

10157N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*52.47	39.50	Fycompa [EI]

▪ PERAMPANEL

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4658

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug.

perampanel 10 mg tablet, 28

10151G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	347.33	39.50	Fycompa [EI]

perampanel 8 mg tablet, 28

10160R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	347.33	39.50	Fycompa [EI]

perampanel 4 mg tablet, 28

10162W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	176.58	39.50	Fycompa [EI]

perampanel 6 mg tablet, 28

10163X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	261.72	39.50	Fycompa [EI]

perampanel 12 mg tablet, 28

10159Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	347.33	39.50	Fycompa [EI]

▪ SULTHIAME

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

sulthiame 50 mg tablet, 200

2099L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	76.77	39.50	Ospolot [PL]

sulthiame 200 mg tablet, 200

2100M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	183.58	39.50	Ospolot [PL]

▪ TOPIRAMATE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5516

Seizures

Clinical criteria:

- Patient must have partial epileptic seizures; OR
- Patient must have primary generalised tonic-clonic seizures; OR
- Patient must have seizures of the Lennox-Gastaut syndrome, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

topiramate 100 mg tablet, 60

8165R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.58	29.79	[a] APO-Topiramate [TX] [a] RBX Topiramate [RA] [a] Topamax [JC] [a] Topiramate GH [GQ]	[a] Epiramax 100 [RW] [a] Tamate [AF] [a] Topiramate AN [EA] [a] Topiramate Sandoz [SZ]

topiramate 200 mg tablet, 60

8166T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	40.48	39.50	[a] APO-Topiramate [TX] [a] RBX Topiramate [RA] [a] Topamax [JC] [a] Topiramate GH [GQ]	[a] Epiramax 200 [RW] [a] Tamate [AF] [a] Topiramate AN [EA] [a] Topiramate Sandoz [SZ]

▪ TOPIRAMATE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5173

Seizures

Clinical criteria:

- Patient must have partial epileptic seizures; OR
- Patient must have primary generalised tonic-clonic seizures; OR
- Patient must have seizures of the Lennox-Gastaut syndrome, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, **AND**
- Patient must be unable to take a solid dose form of topiramate.

topiramate 15 mg capsule, 60

8371N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	19.18	20.39	Topamax Sprinkle [JC]

topiramate 25 mg capsule, 60

8372P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	17.75	18.96	Topamax Sprinkle [JC]

topiramate 50 mg capsule, 60

8520K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	22.19	23.40	Topamax Sprinkle [JC]

▪ TOPIRAMATE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5516

Seizures

Clinical criteria:

- Patient must have partial epileptic seizures; OR
- Patient must have primary generalised tonic-clonic seizures; OR
- Patient must have seizures of the Lennox-Gastaut syndrome, **AND**
- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

Authority required (STREAMLINED)

5325

Migraine

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must have experienced an average of 3 or more migraines per month over a period of at least 6 months, **AND**
- Patient must have a contraindication to beta-blockers, as described in the relevant TGA-approved Product Information; OR
- Patient must have experienced intolerance of a severity necessitating permanent withdrawal during treatment with a beta-blocker, **AND**
- Patient must have a contraindication to pizotifen because the weight gain associated with this drug poses an unacceptable risk; OR
- Patient must have experienced intolerance of a severity necessitating permanent withdrawal during treatment with pizotifen.

Details of the contraindication and/or intolerance(s) must be documented in the patient's medical records when treatment is initiated.

topiramate 50 mg tablet, 60

8164Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.21	23.42	[a] APO-Topiramate [TX] [a] RBX Topiramate [RA] [a] Topamax [JC] [a] Topiramate GH [GQ]	[a] Epiramax 50 [RW] [a] Tamate [AF] [a] Topiramate AN [EA] [a] Topiramate Sandoz [SZ]

topiramate 25 mg tablet, 60

8163P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.86	19.07	[a] APO-Topiramate [TX] [a] RBX Topiramate [RA] [a] Topamax [JC] [a] Topiramate GH [GQ]	[a] Epiramax 25 [RW] [a] Tamate [AF] [a] Topiramate AN [EA] [a] Topiramate Sandoz [SZ]

▪ ZONISAMIDE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4928

Partial epileptic seizures

Clinical criteria:

- The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

zonisamide 50 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9389E NP	1	5	..	30.04	31.25	[a] APO-Zonisamide [TX]	[a] Zonegran [SA]

zonisamide 25 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9388D NP	1	5	..	22.45	23.66	[a] APO-Zonisamide [TX]	[a] Zonegran [SA]

zonisamide 100 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9390F NP	2	5	..	*74.23	39.50	[a] APO-Zonisamide [TX]	[a] Zonegran [SA]

ANTI-PARKINSON DRUGS

ANTICHOLINERGIC AGENTS

Tertiary amines

BENZHEXOL

benzhexol hydrochloride 5 mg tablet, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1110K NP	1	1	..	24.50	25.71	Artane [RW]

benzhexol hydrochloride 2 mg tablet, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1109J NP	1	2	..	18.85	20.06	Artane [RW]

BIPERIDEN

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

biperiden hydrochloride 2 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2544X NP	2	2	..	*23.05	24.26	Akineton [GH]

Ethers of tropine or tropine derivatives

BENZATROPINE

benzatropine mesilate 2 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2362H NP	1	2	..	18.28	19.49	Benztrop [PL]

benzatropine mesilate 2 mg/2 mL injection, 10 x 2 mL vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10013B NP	1	..	..	263.28	39.50	Benztropine Omega [FK]

benzatropine mesilate 2 mg/2 mL injection, 10 x 2 mL vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10027R DP	1	..	..	263.28	39.50	Benztropine Omega [FK]

DOPAMINERGIC AGENTS

Dopa and dopa derivatives

LEVODOPA + BENSERAZIDE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 100 mg + benserazide 25 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2225D NP	1	5	..	37.94	39.15	Madopar 125 [RO]

levodopa 50 mg + benserazide 12.5 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2227F NP	1	5	..	24.79	26.00	Madopar 62.5 [RO]

levodopa 100 mg + benserazide 25 mg modified release capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2231K NP	1	5	..	40.61	39.50	Madopar HBS [RO]

LEVODOPA with BENSERAZIDE Dispersible tablet 100 mg-25 mg, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8219N NP	1	5	..	37.94	39.15	Madopar Rapid 125 [RO]

levodopa 100 mg + benserazide 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2229H NP	1	5	..	37.94	39.15	Madopar 125 [RO]

levodopa 200 mg + benserazide 50 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2228G NP	1	5	..	48.23	39.50	Madopar [RO]

levodopa 200 mg + benserazide 50 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2226E NP	1	5	..	48.23	39.50	Madopar [RO]

LEVODOPA with BENSERAZIDE Dispersible tablet 50 mg-12.5 mg, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8218M NP	1	5	..	24.79	26.00	Madopar Rapid 62.5 [RO]

▪ LEVODOPA + CARBIDOPA ANHYDROUS

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 100 mg + carbidopa anhydrous 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1242J NP	1	5	..	38.80	39.50	[a] Kinson [AF]
			[B]5.75	44.55	39.50	[a] Sinemet 100/25 [MK]

levodopa 250 mg + carbidopa anhydrous 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1245M NP	1	5	..	45.26	39.50	Sinemet [MK]

▪ LEVODOPA + CARBIDOPA ANHYDROUS

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease
Clinical criteria:

- The condition must be one in which fluctuations in motor function are not adequately controlled by frequent dosing with conventional formulations of levodopa with decarboxylase inhibitor.

levodopa 200 mg + carbidopa anhydrous 50 mg modified release tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1255C NP	1	5	..	66.95	39.50	Sinemet CR [MK]

▪ LEVODOPA + CARBIDOPA ANHYDROUS

Note Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5473

Advanced Parkinson disease
Treatment Phase: Maintenance therapy
Clinical criteria:

- Patient must have severe disabling motor fluctuations not adequately controlled by oral therapy, **AND**
- Patient must have been commenced on treatment in a hospital-based movement disorder clinic.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL intestinal gel, 7 x 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8970D NP	8	5	..	*11685.47	39.50	Duodopa [VE]

▪ LEVODOPA + CARBIDOPA ANHYDROUS + ENTACAPONE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease
Clinical criteria:

- Patient must be being treated with levodopa decarboxylase inhibitor combinations, **AND**
- Patient must be experiencing fluctuations in motor function due to end-of-dose effect.

Restricted benefit
Parkinson disease
Clinical criteria:

- Patient must be stabilised on concomitant treatment with levodopa decarboxylase inhibitor combinations and entacapone.

levodopa 125 mg + carbidopa anhydrous 31.25 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9345W NP	2	4	..	*345.87	39.50	Stalevo 125/31.25/200mg [NV]

levodopa 50 mg + carbidopa anhydrous 12.5 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8797B NP	2	4	..	*302.31	39.50	Stalevo 50/12.5/200mg [NV]

levodopa 200 mg + carbidopa anhydrous 50 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9292C NP	2	4	..	*393.13	39.50	Stalevo 200/50/200mg [NV]

levodopa 150 mg + carbidopa anhydrous 37.5 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8799D NP	2	4	..	*364.49	39.50	Stalevo 150/37.5/200mg [NV]

levodopa 100 mg + carbidopa anhydrous 25 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8798C NP	2	4	..	*333.41	39.50	Stalevo 100/25/200mg [NV]

levodopa 75 mg + carbidopa anhydrous 18.75 mg + entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9344T NP	2	4	..	*316.01	39.50	Stalevo 75/18.75/200mg [NV]

Adamantane derivatives

▪ AMANTADINE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease
Clinical criteria:

- The condition must not be drug induced.

amantadine hydrochloride 100 mg capsule, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3016R NP	1	5	..	42.81	39.50	Symmetrel 100 [NV]

Dopamine agonists

▪ BROMOCRIPTINE

Caution Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Restricted benefit
Acromegaly

Restricted benefit
Parkinson disease

Restricted benefit
Pathological hyperprolactinaemia

Clinical criteria:
- Patient must be one in whom surgery is not indicated.

Restricted benefit
Pathological hyperprolactinaemia

Clinical criteria:
- Patient must have had surgery for this condition with incomplete resolution.

Restricted benefit
Pathological hyperprolactinaemia

Clinical criteria:
- Patient must be one in whom radiotherapy is not indicated.

Restricted benefit
Pathological hyperprolactinaemia

Clinical criteria:
- Patient must have had radiotherapy for this condition with incomplete resolution.

bromocriptine 2.5 mg tablet, 30

1443Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*32.83	34.04	Parlodel [SZ]

▪ CABERGOLINE

Caution Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease

cabergoline 2 mg tablet, 30

8394T NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	76.11	39.50	Cabaser [PF]

cabergoline 1 mg tablet, 30

8393R NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	59.60	39.50	Cabaser [PF]

▪ PRAMIPEXOLE

Caution Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease

pramipexole dihydrochloride monohydrate 250 microgram tablet, 100

9152Q NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	28.97	30.18	[a] APO-Pramipexole [TX] [a] Sifrol [BY] [a] Simpral [AF]	[a] Pramipexole AN [EA] [a] Simipex 0.25 [RW]

pramipexole dihydrochloride monohydrate 125 microgram tablet, 30

9151P NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	13.82	15.03	[a] APO-Pramipexole [TX] [a] Sifrol [BY]	[a] Pramipexole AN [EA] [a] Simipex 0.125 [RW]

						[a] Simpral [AF]	

pramipexole dihydrochloride monohydrate 1 mg tablet, 100

9153R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	89.14	39.50	[a] APO-Pramipexole [TX] [a] Sifrol [BY] [a] Simpral [AF]	[a] Pramipexole AN [EA] [a] Simipex 1 [RW]

▪ PRAMIPEXOLE

Caution Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Parkinson disease

pramipexole dihydrochloride monohydrate 1.5 mg modified release tablet, 30

3420B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	41.63	39.50	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 750 microgram modified release tablet, 30

3419Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.36	27.57	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 4.5 mg modified release tablet, 30

3422D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	111.03	39.50	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 3 mg modified release tablet, 30

3421C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	77.72	39.50	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 2.25 mg modified release tablet, 30

5143Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	56.89	39.50	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 375 microgram modified release tablet, 30

3418X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.85	20.06	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

pramipexole dihydrochloride monohydrate 3.75 mg modified release tablet, 30

5145T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	92.98	39.50	[a] APO-Pramipexole ER [TX] [a] Sifrol ER [BY]	[a] Pramipexole XR GP [AF] [a] SIMIPEX XR [RW]

▪ PRAMIPEXOLE

Caution Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Note This drug is not PBS-subsidised for Restless Legs Syndrome secondary to other causes

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Primary severe restless legs syndrome
Clinical criteria:

- Patient must manifest all 4 diagnostic criteria for Restless Legs Syndrome, **AND**

- Patient must have a baseline International Restless Legs Syndrome Rating Scale (IRLSRS) score greater than or equal to 21 points prior to initiation of pramipexole.

The date and IRLSRS score must be documented in the patient's medical records at the time pramipexole treatment is initiated.

The diagnostic criteria for Restless Legs Syndrome are:

(a) An urge to move the legs usually accompanied or caused by unpleasant sensations in the legs; and

(b) The urge to move or unpleasant sensations begin or worsen during periods of rest or inactivity such as lying or sitting; and

(c) The urge to move or unpleasant sensations are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues; and

(d) The urge to move or unpleasant sensations are worse in the evening or night than during the day or only occur during the evening or night.

pramipexole dihydrochloride monohydrate 250 microgram tablet, 100

9394K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	28.97	30.18	Sifrol [BY]

pramipexole dihydrochloride monohydrate 125 microgram tablet, 30

9393J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	13.82	15.03	Sifrol [BY]

▪ ROTIGOTINE

Restricted benefit

Parkinson disease

Clinical criteria:

- The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.

rotigotine 6 mg/24 hours patch, 28

2410W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	108.51	39.50	Neupro [UC]

rotigotine 4 mg/24 hours patch, 28

2384L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	96.94	39.50	Neupro [UC]

rotigotine 8 mg/24 hours patch, 28

11140H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	119.43	39.50	Neupro [UC]

▪ ROTIGOTINE

Restricted benefit

Parkinson disease

Clinical criteria:

- The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.

rotigotine 2 mg/24 hours patch, 28

2385M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	75.48	39.50	Neupro [UC]

Monoamine oxidase B inhibitors

▪ RASAGILINE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Parkinson disease

RASAGILINE Tablet 1 mg (as mesilate), 30

1952R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	115.79	39.50	Azilect [TB]

▪ SELEGILINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Late stage Parkinson disease

Clinical criteria:

- The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.

selegiline hydrochloride 5 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1973W NP	1	5	..	53.13	39.50	Eldepryl [AS]

Other dopaminergic agents

▪ ENTACAPONE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Parkinson disease

Clinical criteria:

- The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination, **AND**
- Patient must be experiencing fluctuations in motor function due to end-of-dose effect.

entacapone 200 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8367J NP	2	4	..	*257.89	39.50	Comtan [NV]

▪ PSYCHOLEPTICS

ANTIPSYCHOTICS

Phenothiazines with aliphatic side-chain

▪ CHLORPROMAZINE

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

chlorpromazine hydrochloride 5 mg/mL oral liquid, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1201F NP	‡1	5	..	16.35	17.56	Largactil [SW]

chlorpromazine hydrochloride 50 mg/2 mL injection, 10 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1195X NP	1	..	..	22.70	23.91	Largactil [SW]

chlorpromazine hydrochloride 100 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1199D NP	1	5	..	20.19	21.40	Largactil [SW]

chlorpromazine hydrochloride 10 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1196Y NP	1	5	..	14.77	15.98	Largactil [SW]

chlorpromazine hydrochloride 25 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1197B NP	1	5	..	15.28	16.49	Largactil [SW]

Phenothiazines with piperazine structure

▪ TRIFLUOPERAZINE

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

trifluoperazine 1 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2185B NP	1	5	..	19.42	20.63	Stelazine [GH]

trifluoperazine 5 mg tablet, 100

2186C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	25.22	26.43	Stelazine [GH]

trifluoperazine 2 mg tablet, 100

2386N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	23.50	24.71	Stelazine [GH]

Phenothiazines with piperidine structure

▪ PERICIAZINE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

periciazine 10 mg tablet, 100

3053Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.35	19.56	Neulactil [SW]

periciazine 2.5 mg tablet, 100

3052P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.62	15.83	Neulactil [SW]

Butyrophenone derivatives

▪ HALOPERIDOL

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

haloperidol 1.5 mg tablet, 100

2767P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.80	16.01	Serenace [QA]

haloperidol 5 mg tablet, 50

2770T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.61	15.82	Serenace [QA]

haloperidol 2 mg/mL oral liquid, 100 mL

2763K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	22.68	23.89	Serenace [QA]

haloperidol 500 microgram tablet, 100

2761H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	14.51	15.72	Serenace [QA]

haloperidol 5 mg/mL injection, 10 x 1 mL ampoules

2768Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	24.20	25.41	Serenace [QA]

▪ HALOPERIDOL DECANOATE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

haloperidol (as decanoate) 50 mg/mL injection, 5 x 1 mL vials

2765M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	30.34	31.55	Haldol decanoate [JC]

haloperidol (as decanoate) 150 mg/3 mL injection, 5 x 3 mL ampoules

2766N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	49.67	39.50	Haldol decanoate [JC]

Indole derivatives

▪ LURASIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia

lurasidone hydrochloride 40 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10526B NP	1	5	..	77.72	39.50	Latuda [SE]

lurasidone hydrochloride 80 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10529E NP	1	5	..	144.35	39.50	Latuda [SE]

▪ ZIPRASIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia
Authority required (STREAMLINED)
5742
Acute mania or mixed episodes
Clinical criteria:

- The condition must be associated with bipolar I disorder, **AND**
- The treatment must be as monotherapy, **AND**
- The treatment must be limited to up to 6 months per episode.

ziprasidone 80 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9073M NP	1	5	..	189.38	39.50	[a] APO-Ziprasidone [TX] [a] ZIPROX [RW]	[a] Zeldox [PF]

ziprasidone 20 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9070J NP	1	5	..	55.69	39.50	[a] APO-Ziprasidone [TX] [a] ZIPROX [RW]	[a] Zeldox [PF]

ziprasidone 60 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9072L NP	1	5	..	144.63	39.50	[a] APO-Ziprasidone [TX] [a] ZIPROX [RW]	[a] Zeldox [PF]

ziprasidone 40 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9071K NP	1	5	..	100.44	39.50	[a] APO-Ziprasidone [TX] [a] ZIPROX [RW]	[a] Zeldox [PF]

Thioxanthene derivatives

▪ FLUPENTIXOL DECANOATE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

flupentixol decanoate 20 mg/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2255Q NP	1	..	..	23.34	24.55	Fluanxol Depot [LU]

flupentixol decanoate 100 mg/mL injection, 5 x 1 mL ampoules

2257T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	48.44	39.50	Fluanxol Concentrated Depot [LU]

▪ ZUCLOPENTHIXOL DECANOATE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

zuclopenthixol decanoate 200 mg/mL injection, 5 x 1 mL ampoules

8097E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	29.19	30.40	Clopixol Depot [LU]

Diazepines, oxazepines, thiazepines and oxepines

▪ ASENAPINE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia
Authority required (STREAMLINED)
5773
Acute mania or mixed episodes
Clinical criteria:
- The condition must be associated with bipolar I disorder, **AND**
- The treatment must be limited to up to 6 months per episode.

Authority required (STREAMLINED)
5719
Bipolar I disorder
Clinical criteria:
- The treatment must be maintenance therapy, **AND**
- The treatment must be as monotherapy.

asenapine 5 mg sublingual wafer, 60

5140M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	141.19	39.50	Saphris [LU]

asenapine 10 mg sublingual wafer, 60

5141N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	229.26	39.50	Saphris [LU]

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 2.5 mg and pharmaceutical benefits that have the form olanzapine tablet 2.5 mg (as benzoate) are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:
- The treatment must be maintenance therapy.

olanzapine 2.5 mg tablet, 28

1024X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	13.86	15.07	[a] Olanzapine generichealth 2.5 [GQ]

olanzapine 2.5 mg tablet, 28

8170B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.86	15.07	[a] APO-Olanzapine [TX] [a] Olanzacor 2.5 [CR] [a] Olanzapine-DRLA [RZ] [a] Olanzapine Sandoz [SZ] [a] PRYZEX [RW] [a] Zypine [AF]	[a] Chem mart Olanzapine [CH] [a] Olanzapine AN [EA] [a] Olanzapine RBX [RA] [a] Ozin 2.5 [DO] [a] Terry White Chemists Olanzapine [TW]
			[B]3.00	16.86	15.07	[a] Zyprexa [LY]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 5 mg and pharmaceutical benefits that have the form olanzapine tablet 5 mg (as benzoate) are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 5 mg tablet, 28

1037N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	16.57	17.78	[a] Olanzapine generichealth 5 [GQ]

olanzapine 5 mg tablet, 28

8185T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.57	17.78	[a] APO-Olanzapine [TX] [a] Olanzacor 5 [CR] [a] Olanzapine-DRLA [RZ] [a] Olanzapine Sandoz [SZ] [a] PRYZEX [RW] [a] Zypine [AF]	[a] Chem mart Olanzapine [CH] [a] Olanzapine AN [EA] [a] Olanzapine RBX [RA] [a] Ozin 5 [DO] [a] Terry White Chemists Olanzapine [TW]
			[B]3.00	19.57	17.78	[a] Zyprexa [LY]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 7.5 mg and pharmaceutical benefits that have the form olanzapine tablet 7.5 mg (as benzoate) are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 7.5 mg tablet, 28

1041T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	19.40	20.61	[a] Olanzapine generichealth 7.5 [GQ]

olanzapine 7.5 mg tablet, 28

8186W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.40	20.61	[a] APO-Olanzapine [TX] [a] Olanzacor 7.5 [CR] [a] Olanzapine-DRLA [RZ]	[a] Chem mart Olanzapine [CH] [a] Olanzapine AN [EA] [a] Olanzapine RBX [RA]

				[a] Olanzapine Sandoz [SZ]	[a] Ozin 7.5 [DO]
				[a] PRYZEX [RW]	[a] Terry White Chemists Olanzapine [TW]
				[a] Zypine [AF]	
	[B]3.00	22.40	20.61	[a] Zyprexa [LY]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 10 mg and pharmaceutical benefits that have the form olanzapine tablet 10 mg (as benzoate) are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 10 mg tablet, 28

1042W (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	22.16	23.37	[a] Olanzapine generichealth 10 [GQ]

olanzapine 10 mg tablet, 28

8187X (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	22.16	23.37	[a] APO-Olanzapine [TX]	[a] Chem mart Olanzapine [CH]
					[a] Olanzacor 10 [CR]	[a] Olanzapine AN [EA]
					[a] Olanzapine-DRLA [RZ]	[a] Olanzapine RBX [RA]
					[a] Olanzapine Sandoz [SZ]	[a] Ozin 10 [DO]
					[a] PRYZEX [RW]	[a] Terry White Chemists Olanzapine [TW]
					[a] Zypine [AF]	
		[B]3.00	25.16	23.37	[a] Zyprexa [LY]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 5 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 5 mg are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 5 mg wafer, 28

8433W (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	16.57	17.78	[a] Zypine ODT [AF]
		[B]3.00	19.57	17.78	[a] Zyprexa Zydis [LY]

OLANZAPINE Tablet 5 mg (orally disintegrating), 28

3381Y (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	16.57	17.78	[a] APO-Olanzapine ODT [TX]	[a] Olanzapine AN ODT [EA]
					[a] Olanzapine ODT-DRLA [RZ]	[a] Olanzapine ODT generichealth 5 [GQ]
					[a] Olanzapine Sandoz ODT 5 [SZ]	[a] Ozin ODT 5 [DO]
					[a] PRYZEX ODT [RW]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 10 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 10 mg are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 10 mg wafer, 28

8434X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	22.16	23.37	[a] Zypine ODT [AF]
		[B]3.00	25.16	23.37	[a] Zyprexa Zydis [LY]

OLANZAPINE Tablet 10 mg (orally disintegrating), 28

3382B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	22.16	23.37	[a] APO-Olanzapine ODT [TX]	[a] Olanzapine AN ODT [EA]
					[a] Olanzapine ODT-DRLA [RZ]	[a] Olanzapine ODT generichealth 10 [GQ]
					[a] Olanzapine Sandoz ODT 10 [SZ]	[a] Ozin ODT 10 [DO]
					[a] PRYZEX ODT [RW]	

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 15 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 15 mg are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869
Bipolar I disorder
Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 15 mg tablet, 28

3384D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	27.70	28.91	[a] APO-Olanzapine ODT [TX]	[a] Olanzapine AN ODT [EA]
					[a] Olanzapine Sandoz ODT 15 [SZ]	[a] Ozin ODT 15 [DO]

olanzapine 15 mg wafer, 28

8952E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	27.70	28.91	[a] Zypine ODT [AF]
		[B]3.00	30.70	28.91	[a] Zyprexa Zydis [LY]

▪ OLANZAPINE

Note Pharmaceutical benefits that have the form olanzapine tablet 20 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 20 mg are equivalent for the purposes of substitution.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5856
Schizophrenia
Authority required (STREAMLINED)
5869

Bipolar I disorder

Clinical criteria:

- The treatment must be maintenance therapy.

olanzapine 20 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3385E NP	1	5	..	33.24	34.45	[a] APO-Olanzapine ODT [TX] [a] Olanzapine Sandoz ODT 20 [SZ]	[a] Olanzapine AN ODT [EA] [a] Ozin ODT 20 [DO]

olanzapine 20 mg wafer, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8953F NP	1	5	..	33.24	34.45	[a] Zypine ODT [AF]
			[B]3.00	36.24	34.45	[a] Zyprexa Zydis [LY]

▪ OLANZAPINE

Caution Monitor for post-injection syndrome for at least two hours after each injection.

Note Special Pricing Arrangements apply.

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4304

Schizophrenia

olanzapine 300 mg modified release injection [1 vial] (&) inert substance diluent [3 mL vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9295F NP	2	5	..	*803.77	39.50	Zyprexa Relprevv [LY]

olanzapine 210 mg modified release injection [1 vial] (&) inert substance diluent [3 mL vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9294E NP	2	5	..	*495.77	39.50	Zyprexa Relprevv [LY]

olanzapine 405 mg modified release injection [1 vial] (&) inert substance diluent [3 mL vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9303P NP	1	5	..	495.77	39.50	Zyprexa Relprevv [LY]

▪ QUETIAPINE

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4246

Schizophrenia

Authority required (STREAMLINED)

5611

Acute mania

Clinical criteria:

- The condition must be associated with bipolar I disorder, **AND**
- The treatment must be as monotherapy, **AND**
- The treatment must be limited to up to 6 months per episode.

Authority required (STREAMLINED)

5639

Bipolar I disorder

Clinical criteria:

- The treatment must be maintenance therapy.

quetiapine 200 mg modified release tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9203J NP	1	5	..	45.07	39.50	[a] APO-Quetiapine XR [TX] [a] QUETIAPINE-AS XR [RW] [a] Tevatiapine XR [TB]	[a] QUEPINE XR [RF] [a] Seroquel XR [AP]

quetiapine 100 mg tablet, 90

8457D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.61	28.82	[a] APO-Quetiapine [TX] [a] Delucon 100 [DO] [a] Pharmacor Quetiapine 100 [CR] [a] Quetiapine Actavis 100 [ED] [a] Quetiapine-DRLA [RZ] [a] Quetiapine RBX [RA] [a] Seroquel [AP] [a] Terry White Chemists Quetiapine [TW]	[a] Chem mart Quetiapine [CH] [a] Kaptan [ER] [a] Quetia 100 [RW] [a] Quetiapine AN [EA] [a] Quetiapine GH 100 [GQ] [a] Quetiapine Sandoz [SZ] [a] Syquet [AF]

quetiapine 50 mg modified release tablet, 60

9202H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.77	23.98	[a] APO-Quetiapine XR [TX] [a] QUETIAPINE-AS XR [RW] [a] Tevatiapine XR [TB]	[a] QUEPINE XR [RF] [a] Seroquel XR [AP]

quetiapine 300 mg modified release tablet, 60

9204K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	54.73	39.50	[a] APO-Quetiapine XR [TX] [a] QUETIAPINE-AS XR [RW] [a] Tevatiapine XR [TB]	[a] QUEPINE XR [RF] [a] Seroquel XR [AP]

quetiapine 400 mg modified release tablet, 60

9205L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	70.58	39.50	[a] APO-Quetiapine XR [TX] [a] QUETIAPINE-AS XR [RW] [a] Tevatiapine XR [TB]	[a] QUEPINE XR [RF] [a] Seroquel XR [AP]

quetiapine 200 mg tablet, 60

8458E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	33.59	34.80	[a] APO-Quetiapine [TX] [a] Delucon 200 [DO] [a] Pharmacor Quetiapine 200 [CR] [a] Quetiapine Actavis 200 [ED] [a] Quetiapine-DRLA [RZ] [a] Quetiapine RBX [RA] [a] Seroquel [AP] [a] Terry White Chemists Quetiapine [TW]	[a] Chem mart Quetiapine [CH] [a] Kaptan [ER] [a] Quetia 200 [RW] [a] Quetiapine AN [EA] [a] Quetiapine GH 200 [GQ] [a] Quetiapine Sandoz [SZ] [a] Syquet [AF]

quetiapine 150 mg modified release tablet, 60

5458G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.61	28.82	[a] QUEPINE XR [RW] [a] Tevatiapine XR [TB]	[a] Seroquel XR [AP]

quetiapine 300 mg tablet, 60

8580N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	44.12	39.50	[a] APO-Quetiapine [TX] [a] Delucon 300 [DO] [a] Pharmacor Quetiapine 300 [CR] [a] Quetiapine Actavis 300 [ED] [a] Quetiapine-DRLA [RZ] [a] Quetiapine RBX [RA] [a] Seroquel [AP] [a] Terry White Chemists Quetiapine [TW]	[a] Chem mart Quetiapine [CH] [a] Kaptan [ER] [a] Quetia 300 [RW] [a] Quetiapine AN [EA] [a] Quetiapine GH 300 [GQ] [a] Quetiapine Sandoz [SZ] [a] Syquet [AF]

▪ QUETIAPINE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4391

Schizophrenia

Clinical criteria:

- The treatment must be for dose titration purposes.

Authority required (STREAMLINED)

4396

Acute mania

Clinical criteria:

- The condition must be associated with bipolar I disorder, **AND**
- The treatment must be as monotherapy, **AND**
- The treatment must be for dose titration purposes.

Authority required (STREAMLINED)

4385

Bipolar I disorder

Clinical criteria:

- The treatment must be maintenance therapy, **AND**
- The treatment must be for dose titration purposes.

quetiapine 25 mg tablet, 60

8456C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	16.93	18.14	[a] APO-Quetiapine [TX] [a] Delucon 25 [DO] [a] Pharmacor Quetiapine 25 [CR] [a] Quetiapine AN [EA] [a] Quetiapine GH 25 [GQ] [a] Quetiapine Sandoz [SZ] [a] Syquet [AF]	[a] Chem mart Quetiapine [CH] [a] Kaptan [ER] [a] Quetia 25 [RW] [a] Quetiapine-DRLA [RZ] [a] Quetiapine RBX [RA] [a] Seroquel [AP] [a] Terry White Chemists Quetiapine [TW]

Benzamides

▪ AMISULPRIDE

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4246

Schizophrenia

amisulpride 200 mg tablet, 60

8595J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	41.08	39.50	[a] Amisulpride 200 Winthrop [WA] [a] Amisulpride Sandoz [SZ] [a] Pharmacor Amisulpride [CR] [a] Sulprix [AF]	[a] Amisulpride AN [EA] [a] APO-Amisulpride [TX] [a] Solian 200 [SW]

amisulpride 100 mg/mL oral liquid, 60 mL

8736T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*140.47	39.50	Solian Solution [SW]

amisulpride 400 mg tablet, 60

8596K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	65.46	39.50	[a] Amipride 400 [RW] [a] Amisulpride AN [EA] [a] APO-Amisulpride [TX] [a] Solian 400 [SW]	[a] Amisulpride 400 Winthrop [WA] [a] Amisulpride Sandoz [SZ] [a] Pharmacor Amisulpride [CR] [a] Sulprix [AF]

amisulpride 100 mg tablet, 30

8594H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	18.05	19.26	[a] Amisulpride 100 Winthrop [WA] [a] Amisulpride Sandoz [SZ] [a] Pharmacor Amisulpride [CR] [a] Sulprix [AF]	[a] Amisulpride AN [EA] [a] APO-Amisulpride [TX] [a] Solian 100 [SW]

Other antipsychotics

▪ ARIPIPRAZOLE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia

aripiprazole 30 mg tablet, 30

8720Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	235.28	39.50	[a] Abilify [OS] [a] APO-Aripiprazole [TX] [a] Aripiprazole GH [GQ] [a] Tevaripiprazole [TB]	[a] Abyraz [AF] [a] Aripiprazole AN [EA] [a] Aripiprazole Sandoz [SZ]

aripiprazole 20 mg tablet, 30

8719X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	193.94	39.50	[a] Abilify [OS] [a] APO-Aripiprazole [TX] [a] Aripiprazole GH [GQ] [a] Tevaripiprazole [TB]	[a] Abyraz [AF] [a] Aripiprazole AN [EA] [a] Aripiprazole Sandoz [SZ]

aripiprazole 10 mg tablet, 30

8717T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	116.89	39.50	[a] Abilify [OS] [a] APO-Aripiprazole [TX] [a] Aripiprazole GH [GQ] [a] Tevaripiprazole [TB]	[a] Abyraz [AF] [a] Aripiprazole AN [EA] [a] Aripiprazole Sandoz [SZ]

aripiprazole 15 mg tablet, 30

8718W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	161.22	39.50	[a] Abilify [OS] [a] APO-Aripiprazole [TX] [a] Aripiprazole GH [GQ] [a] Tevaripiprazole [TB]	[a] Abyraz [AF] [a] Aripiprazole AN [EA] [a] Aripiprazole Sandoz [SZ]

aripiprazole 400 mg injection: modified release [1 x 400 mg vial] (&) inert substance diluent [1 vial], 1 pack

10219W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	373.70	39.50	Abilify Maintena [LU]

aripiprazole 300 mg injection: modified release [1 x 300 mg vial] (&) inert substance diluent [1 vial], 1 pack

10224D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	299.91	39.50	Abilify Maintena [LU]

▪ BREXPIPRAZOLE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia

brexpiprazole 4 mg tablet, 30

11184P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	142.37	39.50	Rexulti [LU]

brexpiprazole 1 mg tablet, 30

11189X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	142.37	39.50	Rexulti [LU]

brexpiprazole 3 mg tablet, 30

11190Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	142.37	39.50	Rexulti [LU]

brexpiprazole 2 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11188W NP	1	5	..	142.37	39.50	Rexulti [LU]

▪ PALIPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia

paliperidone 3 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9140C NP	1	5	..	74.29	39.50	Invega [JC]

paliperidone 9 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9142E NP	1	5	..	203.00	39.50	Invega [JC]

paliperidone 25 mg modified release injection, 1 syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5100K NP	1	5	..	134.77	39.50	Invega Sustenna [JC]

paliperidone 6 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9141D NP	1	5	..	138.77	39.50	Invega [JC]

paliperidone 50 mg modified release injection, 1 syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5102M NP	1	5	..	260.81	39.50	Invega Sustenna [JC]

paliperidone 100 mg modified release injection, 1 syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5107T NP	1	5	..	414.09	39.50	Invega Sustenna [JC]

paliperidone 150 mg modified release injection, 1 syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5109X NP	1	5	..	414.09	39.50	Invega Sustenna [JC]

paliperidone 75 mg modified release injection, 1 syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5103N NP	1	5	..	337.84	39.50	Invega Sustenna [JC]

▪ PALIPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note Patient dosage is to be determined as per the dose transition table in the Product Information based on the maintenance dose of paliperidone once monthly injection.

Note No increase in the maximum number of repeats may be authorised.

Note No increase in the maximum quantity or number of units may be authorised.

Authority required (STREAMLINED)
6832
Schizophrenia
Clinical criteria:

- Patient must have previously received and be stabilised on PBS-subsidised paliperidone once-monthly injection for at least 4 consecutive months.

paliperidone 350 mg/1.75 mL modified release injection, 1.75 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11094X NP	1	1	..	1219.20	39.50	Invega Trinza [JC]

paliperidone 263 mg/1.315 mL modified release injection, 1.315 mL syringe

11072R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	1003.94	39.50	Invega Trinza [JC]

paliperidone 175 mg/0.875 mL modified release injection, 0.875 mL syringe

11085K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	772.84	39.50	Invega Trinza [JC]

paliperidone 525 mg/2.625 mL modified release injection, 2.625 mL syringe

11066K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	1	..	1219.20	39.50	Invega Trinza [JC]

▪ RISPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
4246
Schizophrenia
Authority required (STREAMLINED)
5907
Acute mania
Clinical criteria:

- The condition must be associated with bipolar I disorder, **AND**
- The treatment must be as adjunctive therapy to mood stabilisers, **AND**
- The treatment must be limited to up to 6 months per episode.

risperidone 1 mg/mL oral liquid, 100 mL

8100H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	112.55	39.50	Risperdal [JC]

risperidone 2 mg tablet, 60

3170W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.36	26.57	[a] APO-Risperidone [TX] [a] Rispa [RW] [a] Rispericor 2 [CR] [a] Risperidone generichealth [GQ] [a] Rispernia [ER]	[a] Ozidal [RA] [a] Risperdal [JC] [a] Risperidone AMNEAL [EF] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]

risperidone 3 mg tablet, 60

3171X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	33.09	34.30	[a] APO-Risperidone [TX] [a] Rispa [RW] [a] Risperidone AMNEAL [EF] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]	[a] Ozidal [RA] [a] Risperdal [JC] [a] Risperidone generichealth [GQ] [a] Rispernia [ER]

risperidone 4 mg tablet, 60

3172Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	40.79	39.50	[a] APO-Risperidone [TX] [a] Rispa [RW] [a] Risperidone AMNEAL [EF] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]	[a] Ozidal [RA] [a] Risperdal [JC] [a] Risperidone generichealth [GQ] [a] Rispernia [ER]

risperidone 1 mg tablet, 60

3169T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.33	18.54	[a] APO-Risperidone [TX] [a] Rispa [RW] [a] Rispericor 1 [CR] [a] Risperidone generichealth [GQ] [a] Rispernia [ER]	[a] Ozidal [RA] [a] Risperdal [JC] [a] Risperidone AMNEAL [EF] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]

▪ RISPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

6897

Severe behavioural disturbances

Clinical criteria:

- Patient must have autism spectrum disorder, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:

- Patient must be under 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

Authority required (STREAMLINED)

6938

Severe behavioural disturbances

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have autism spectrum disorder, **AND**
- Patient must have been commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:

- Patient must be aged 18 years or older.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

risperidone 2 mg tablet, 60

9079W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	25.36	26.57	[a] APO-Risperidone [TX] [a] Rispa [RW] [a] Rispericor 2 [CR] [a] Risperidone generichealth [GQ] [a] Rispernia [ER]	[a] Ozidal [RA] [a] Risperdal [JC] [a] Risperidone AMNEAL [EF] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]

▪ RISPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4246

Schizophrenia

Authority required (STREAMLINED)

5912

Bipolar I disorder

Clinical criteria:

- The condition must be refractory to treatment, **AND**
- The treatment must be in combination with lithium or sodium valproate, **AND**
- The treatment must be maintenance therapy.

risperidone 37.5 mg modified release injection [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

8781E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*345.33	39.50	Risperdal Consta [JC]

risperidone 50 mg modified release injection [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

8782F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*423.51	39.50	Risperdal Consta [JC]

risperidone 25 mg modified release injection [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

8780D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*266.31	39.50	Risperdal Consta [JC]

▪ RISPERIDONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note For item codes 8869T and 1846E, pharmaceutical benefits that have the form tablet 0.5 mg are equivalent for the purposes of substitution.

Authority required (STREAMLINED)
5903
Schizophrenia

risperidone 500 microgram tablet, 20

1846E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
3	5	..	*18.22	19.43	[a] APO-Risperidone [TX]	[a] Risperdal [JC]

risperidone 500 microgram tablet, 60

8869T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	18.22	19.43	[a] Ozidal [RA] [a] Rispericor 0.5 [CR] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]	[a] Rispa [RW] [a] Risperidone AMNEAL [EF] [a] Rispernia [ER]

▪ RISPERIDONE

Caution In placebo controlled trials in elderly patients with dementia there was a significantly higher incidence of cerebrovascular adverse events, such as stroke (including fatalaties) and transient ischaemic attacks, in patients treated with risperidone compared with patients treated with placebo.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5993
Behavioural disturbances
Clinical criteria:
- The condition must be characterised by psychotic symptoms and aggression, **AND**
- Patient must have dementia of the Alzheimer type, **AND**
- Patient must have failed to respond to non-pharmacological methods of treatment, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Authority required (STREAMLINED)
6897
Severe behavioural disturbances
Clinical criteria:
- Patient must have autism spectrum disorder, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:
- Patient must be under 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

Authority required (STREAMLINED)
6938
Severe behavioural disturbances
Treatment Phase: Continuing treatment
Clinical criteria:
- Patient must have autism spectrum disorder, **AND**
- Patient must have been commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:
- Patient must be aged 18 years or older.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

risperidone 1 mg/mL oral liquid, 100 mL

9293D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	112.55	39.50	Risperdal [JC]

risperidone 1 mg tablet, 60

8789N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	17.33	18.54	[a] APO-Risperidone [TX]	[a] Ozidal [RA]
						[a] Rispa [RW]	[a] Risperdal [JC]
						[a] Rispericor 1 [CR]	[a] Risperidone AMNEAL [EF]
						[a] Risperidone generichealth [GQ]	[a] Risperidone Sandoz [SZ]
						[a] Rispernia [ER]	[a] Rixadone [AF]

▪ RISPERIDONE

Caution In placebo controlled trials in elderly patients with dementia there was a significantly higher incidence of cerebrovascular adverse events, such as stroke (including fatalaties) and transient ischaemic attacks, in patients treated with risperidone compared with patients treated with placebo.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note For items 8787L and 1842Y, pharmaceutical benefits that have the form tablet 0.5 mg are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

6010

Behavioural disturbances

Clinical criteria:

- The condition must be characterised by psychotic symptoms and aggression, **AND**
- Patient must have dementia of the Alzheimer type, **AND**
- Patient must have failed to respond to non-pharmacological methods of treatment, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Authority required (STREAMLINED)

6898

Severe behavioural disturbances

Clinical criteria:

- Patient must have autism spectrum disorder, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:

- Patient must be under 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

Authority required (STREAMLINED)

6899

Severe behavioural disturbances

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have autism spectrum disorder, **AND**
- Patient must have been commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age, **AND**
- The treatment must be under the supervision of a paediatrician or psychiatrist, **AND**
- The treatment must be in combination with non-pharmacological measures.

Population criteria:

- Patient must be aged 18 years or older.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism spectrum disorder must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or ICD-10 international classification of mental and behavioural disorders.

risperidone 500 microgram tablet, 20

1842Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	2	..	*18.22	19.43	[a] APO-Risperidone [TX]	[a] Risperdal [JC]

risperidone 500 microgram tablet, 60

8787L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	18.22	19.43	[a] Ozidal [RA] [a] Rispericor 0.5 [CR] [a] Risperidone Sandoz [SZ] [a] Rixadone [AF]	[a] Rispa [RW] [a] Risperidone AMNEAL [EF] [a] Rispernia [ER]

ANXIOLYTICS

Benzodiazepine derivatives

▪ ALPRAZOLAM

Note Pharmaceutical benefits that have the form alprazolam tablet 1 mg are equivalent for the purposes of substitution.
Note The panic disorder must not be attributable to some known organic factor.
Note No increase in the maximum number of repeats may be authorised.

Authority required
Panic disorder
Clinical criteria:

- The treatment must be for use when other treatments have failed; OR
- The treatment must be for use when other treatments are inappropriate.

alprazolam 1 mg tablet, 10

11186R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	17.80	19.01	[a] Alprax 1 [QA]	[a] Kalma 1 [AF]

alprazolam 1 mg tablet, 50

2132F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	0.2	..	..	*22.79	24.00	[a] Alprax 1 [QA]	[a] Kalma 1 [AF]

▪ ALPRAZOLAM

Note Pharmaceutical benefits that have the form alprazolam tablet 500 micrograms are equivalent for the purposes of substitution.
Note The panic disorder must not be attributable to some known organic factor.
Note No increase in the maximum number of repeats may be authorised.

Authority required
Panic disorder
Clinical criteria:

- The treatment must be for use when other treatments have failed; OR
- The treatment must be for use when other treatments are inappropriate.

alprazolam 500 microgram tablet, 10

11187T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	16.74	17.95	[a] Alprax 0.5 [QA]	[a] Kalma 0.5 [AF]

alprazolam 500 microgram tablet, 50

2131E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	0.2	..	..	*21.10	22.31	[a] Alprax 0.5 [QA]	[a] Kalma 0.5 [AF]

▪ ALPRAZOLAM

Note Pharmaceutical benefits that have the form alprazolam tablet 250 micrograms are equivalent for the purposes of substitution.
Note The panic disorder must not be attributable to some known organic factor.
Note No increase in the maximum number of repeats may be authorised.

Authority required
Panic disorder
Clinical criteria:

- The treatment must be for use when other treatments have failed; OR
- The treatment must be for use when other treatments are inappropriate.

alprazolam 250 microgram tablet, 10

11205R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	15.73	16.94	[a] Kalma 0.25 [AF]

alprazolam 250 microgram tablet, 50

2130D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	0.2	..	..	*19.49	20.70	[a] Alprax 0.25 [QA]	[a] Kalma 0.25 [AF]

▪ DIAZEPAM

diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules

5073B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	17.11	18.32	Hospira Pty Limited [PF]

diazepam 5 mg tablet, 50

5072Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.48	13.69	[a] Antenex 5 [AF]	[a] APO-Diazepam [TX]
						[a] Ranzepam [RA]	[a] Valpam 5 [RW]
			[B]2.19	14.67	13.69	[a] Valium [RO]	

diazepam 2 mg tablet, 50

5071X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.41	13.62	[a] APO-Diazepam [TX]	[a] Valpam 2 [RW]
			[B]2.99	15.40	13.62	[a] Antenex 2 [AF]	

▪ DIAZEPAM

Authority required

Chronic spasticity

Population criteria:

- Patient must be under 18 years of age.

diazepam 1 mg/mL oral liquid, 100 mL

2669L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	42.95	39.50	Diazepam Elixir [ON]

▪ DIAZEPAM

Note Authorities for increased maximum quantities and/or repeats for the oral forms of diazepam will be granted only for
(i) the treatment of disabling spasticity; or
(ii) malignant neoplasia (late stage); or
(iii) use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal; or
(iv) use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal.
Up to six months' treatment (i.e. one month's treatment with five repeats) may be requested.

diazepam 5 mg tablet, 50

3162K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.48	13.69	[a] Antenex 5 [AF]	[a] APO-Diazepam [TX]
						[a] Ranzepam [RA]	[a] Valpam 5 [RW]
			[B]2.19	14.67	13.69	[a] Valium [RO]	

diazepam 2 mg tablet, 50

3161J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.41	13.62	[a] APO-Diazepam [TX]	[a] Valpam 2 [RW]
			[B]2.99	15.40	13.62	[a] Antenex 2 [AF]	

▪ DIAZEPAM

Note Authorities for increased maximum quantities and/or repeats for the oral forms of diazepam will be granted only for
(i) the treatment of disabling spasticity; or
(ii) malignant neoplasia (late stage); or
(iii) use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal; or
(iv) use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal.

Note Up to six months' treatment (i.e. one month's treatment with five repeats) may be requested.

diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules

2558P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	17.11	18.32	Hospira Pty Limited [PF]

▪ OXAZEPAM

oxazepam 15 mg tablet, 25

5192G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	12.51	13.72	[a] Alepam 15 [AF]
			[B]2.66	15.17	13.72	[a] Serepax [QA]

oxazepam 30 mg tablet, 25

5193H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.17	13.38	[a] Alepam 30 [AF] [a] Murelax [RW]	[a] APO-Oxazepam [TX]
			[B]2.33	14.50	13.38	[a] Serepax [QA]	

▪ OXAZEPAM

Note Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of oxazepam below.

oxazepam 15 mg tablet, 25

3132W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	12.51	13.72	[a] Alepam 15 [AF]
			[B]2.66	15.17	13.72	[a] Serepax [QA]

oxazepam 30 mg tablet, 25

3133X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.17	13.38	[a] Alepam 30 [AF] [a] Murelax [RW]	[a] APO-Oxazepam [TX]
			[B]2.33	14.50	13.38	[a] Serepax [QA]	

▪ OXAZEPAM

Authority required

Malignant neoplasia (late stage)

Authority required

Anxiety

Clinical criteria:

- Patient must be receiving this drug for the management of anxiety, **AND**
- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

Authority required

Anxiety

Clinical criteria:

- Patient must be receiving this drug for the management of anxiety, **AND**
- Patient must be receiving long-term nursing care, **AND**
- Patient must be one in respect of whom a Carer Allowance is payable as a disabled adult, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

oxazepam 15 mg tablet, 25

3134Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*13.93	15.14	[a] Alepam 15 [AF]
			[B]5.32	*19.25	15.14	[a] Serepax [QA]

oxazepam 30 mg tablet, 25

3135B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*13.25	14.46	[a] Alepam 30 [AF] [a] Murelax [RW]	[a] APO-Oxazepam [TX]
			[B]4.66	*17.91	14.46	[a] Serepax [QA]	

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

▪ NITRAZEPAM

nitrazepam 5 mg tablet, 25

5189D (DP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	12.70	13.91	[a] Alodorm [AF]
		[B]1.24	13.94	13.91	[a] Mogadon [IA]

▪ NITRAZEPAM

Note Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of nitrazepam below.

nitrazepam 5 mg tablet, 25

2723H (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	12.70	13.91	[a] Alodorm [AF]
		[B]1.24	13.94	13.91	[a] Mogadon [IA]

▪ NITRAZEPAM

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required
Myoclonic epilepsy
Authority required
Malignant neoplasia (late stage)
Authority required
Insomnia
Clinical criteria:
- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

Authority required
Insomnia
Clinical criteria:
- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care, **AND**
- Patient must be one in respect of whom a Carer Allowance is payable as a disabled adult, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

nitrazepam 5 mg tablet, 25

2732T (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*14.31	15.52	[a] Alodorm [AF]
		[B]2.48	*16.79	15.52	[a] Mogadon [IA]

▪ TEMAZEPAM

temazepam 10 mg tablet, 25

5221T (DP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	12.17	13.38	[a] APO-Temazepam [TX] [a] Temtabs [FM]	[a] Temaze [AF]
		[B]3.48	15.65	13.38	[a] Normison [QA]	

▪ TEMAZEPAM

Note Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of temazepam.

temazepam 10 mg tablet, 25

2089Y (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	12.17	13.38	[a] APO-Temazepam [TX] [a] Temtabs [FM]	[a] Temaze [AF]
		[B]3.48	15.65	13.38	[a] Normison [QA]	

▪ TEMAZEPAM

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a

patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Malignant neoplasia (late stage)

Authority required

Insomnia

Clinical criteria:

- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care on account of age, infirmity or other condition in a hospital, nursing home or residential facility, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

Authority required

Insomnia

Clinical criteria:

- Patient must be receiving this drug for the management of insomnia, **AND**
- Patient must be receiving long-term nursing care, **AND**
- Patient must be one in respect of whom a Carer Allowance is payable as a disabled adult, **AND**
- Patient must have demonstrated, within the past 6 months, benzodiazepine dependence by an unsuccessful attempt at gradual withdrawal.

temazepam 10 mg tablet, 25

2088X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*13.25	14.46	[a] APO-Temazepam [TX] [a] Temtabs [FM]	[a] Temaze [AF]
			[B]6.96	*20.21	14.46	[a] Normison [QA]	

PSYCHOANALEPTICS

ANTIDEPRESSANTS

Non-selective monoamine reuptake inhibitors

AMITRIPTYLINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

amitriptyline hydrochloride 25 mg tablet, 50

2418G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.79	15.00	[a] Amitriptyline Alphapharm 25 [AL] [a] Chem mart Amitriptyline [CH] [a] Terry White Chemists Amitriptyline [TW]	[a] APO-Amitriptyline 25 [TX] [a] ENTRIP [RW]
			[B]1.96	15.75	15.00	[a] Endep 25 [AF]	

amitriptyline hydrochloride 10 mg tablet, 50

2417F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.60	14.81	[a] Amitriptyline Alphapharm 10 [AL] [a] Chem mart Amitriptyline [CH] [a] Terry White Chemists Amitriptyline [TW]	[a] APO-Amitriptyline 10 [TX] [a] ENTRIP [RW]
			[B]1.95	15.55	14.81	[a] Endep 10 [AF]	

amitriptyline hydrochloride 50 mg tablet, 50

2429W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.19	15.40	[a] Amitriptyline Alphapharm 50 [AL] [a] Chem mart Amitriptyline [CH] [a] Terry White Chemists Amitriptyline [TW]	[a] APO-Amitriptyline 50 [TX] [a] ENTRIP [RW]
			[B]1.95	16.14	15.40	[a] Endep 50 [AF]	

CLOMIPRAMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a

patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Cataplexy

Clinical criteria:

- The condition must be associated with narcolepsy.

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Phobic disorders

Population criteria:

- Patient must be an adult.

clomipramine hydrochloride 25 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1561E NP	1	2	..	17.03	18.24	[a] GenRx Clomipramine [GX]	[a] Placil [AF]
			[B]4.41	21.44	18.24	[a] Anafranil 25 [SZ]	

▪ DOTHIEPIN

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dothiepin hydrochloride 75 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1358L NP	1	2	..	13.66	14.87	Dothep 75 [AF]

dothiepin hydrochloride 25 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1357K NP	1	2	..	13.66	14.87	Dothep 25 [AF]

▪ DOXEPIN

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

doxepin 50 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1012G NP	1	2	..	14.89	16.10	Deptran 50 [AF]

doxepin 10 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1011F NP	1	2	..	13.98	15.19	Deptran 10 [AF]
			[B]7.00	20.98	15.19	Sinequan [PF]

doxepin 25 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1013H NP	1	2	..	14.09	15.30	Deptran 25 [AF]
			[B]7.00	21.09	15.30	Sinequan [PF]

▪ IMIPRAMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

imipramine hydrochloride 25 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2421K NP	1	2	..	18.73	19.94	Tofranil 25 [GH]

imipramine hydrochloride 10 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2420J NP	1	2	..	15.36	16.57	Tofranil 10 [GH]

▪ NORTRIPTYLINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Major depression

Clinical criteria:

- The treatment must be for use when other anti-depressant therapy has failed.

Restricted benefit

Major depression

Clinical criteria:

- The treatment must be for use when other anti-depressant therapy is contraindicated.

nortriptyline 25 mg tablet, 50

2523T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	17.11	18.32	[a] Allegron [RW]	[a] NortriTABS 25 mg [GH]

nortriptyline 10 mg tablet, 50

2522R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	15.87	17.08	[a] Allegron [RW]	[a] NortriTABS 10 mg [GH]

Selective serotonin reuptake inhibitors

▪ CITALOPRAM

Restricted benefit

Major depressive disorders

citalopram 10 mg tablet, 28

8702B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.06	13.27	[a] Celapram [AF] [a] Citalopram AN [EF]	[a] Citalopram Actavis [EA] [a] Talam [RW]

citalopram 20 mg tablet, 28

8220P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.39	13.60	[a] APO-Citalopram [TX] [a] Celapram [AF] [a] Chem mart Citalopram [CH] [a] Citalopram AN [EA] [a] Pharmacor Citalo 20 [CR] [a] Terry White Chemists Citalopram [TW]	[a] Auro-Citalopram 20 [DO] [a] Celica [RA] [a] Citalopram Actavis [ED] [a] Citalopram Sandoz [SZ] [a] Talam [RW]
			[B]7.46	19.85	13.60	[a] Cipramil [LU]	

citalopram 40 mg tablet, 28

8703C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.28	14.49	[a] APO-Citalopram [TX] [a] Celapram [AF] [a] Citalopram AN [EA] [a] Talam [RW]	[a] Auro-Citalopram 40 [DO] [a] Citalopram Actavis [ED] [a] Citalopram Sandoz [SZ]

▪ ESCITALOPRAM

Restricted benefit

Major depressive disorders

escitalopram 10 mg tablet, 28

8700X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.19	14.40	[a] APO-Escitalopram [TX] [a] Chem mart Escitalopram [CH] [a] Escicor 10 [RA] [a] Escitalopram-DRLA [RZ] [a] Escitalopram Sandoz [HX] [a] Esitalo [SZ] [a] LoxaLate [AF] [a] Terry White Chemists Escitalopram [TW]	[a] Blooms the Chemist Escitalopram [IB] [a] Cilopam-S [ER] [a] Escitalopram AN [EA] [a] Escitalopram generichealth [GQ] [a] Esipram [CF] [a] Lexam 10 [RW] [a] Pharmacor Escitalopram 10 [CR]
			[B]8.49	21.68	14.40	[a] Lexapro [LU]	

escitalopram 20 mg tablet, 28

8701Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.21	14.42	[a] APO-Escitalopram [TX]	[a] Blooms the Chemist Escitalopram [IB]
						[a] Chem mart Escitalopram [CH]	[a] Cilopam-S [ER]
						[a] Escicor 20 [RA]	[a] Escitalopram AN [EA]
						[a] Escitalopram-DRLA [RZ]	[a] Escitalopram generichealth [GQ]
						[a] Escitalopram Sandoz [HX]	[a] Esipram [CF]
						[a] Esitalo [SZ]	[a] Lexam 20 [RW]
						[a] LoxaLate [AF]	[a] Pharmacor Escitalopram 20 [CR]
						[a] Terry White Chemists Escitalopram [TW]	
			[B]8.84	22.05	14.42	[a] Lexapro [LU]	

▪ ESCITALOPRAM

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must have been assessed by a psychiatrist.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must have been assessed by a psychiatrist.

escitalopram 10 mg tablet, 28

9432K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	13.19	14.40	[a] Esipram [CF]
			[B]8.49	21.68	14.40	[a] Lexapro [LU]

escitalopram 20 mg tablet, 28

9433L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	13.21	14.42	[a] Esipram [CF]
			[B]8.84	22.05	14.42	[a] Lexapro [LU]

▪ ESCITALOPRAM

Restricted benefit

Major depressive disorders

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**

- Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must have been assessed by a psychiatrist.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

- The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**
- Patient must not have responded to non-pharmacological therapy, **AND**
- Patient must have been assessed by a psychiatrist.

escitalopram 20 mg/mL oral liquid, 15 mL

10181W (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	37.06	38.27	Lexapro [LU]

▪ FLUOXETINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

fluoxetine 20 mg tablet, 28

8270G (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	14.80	16.01	[a] Lovan 20 Tab [AL]	[a] Zactin Tablet [AF]
		[B]1.18	15.98	16.01	[a] Prozac Tab [LY]	

fluoxetine 20 mg capsule, 28

1434L (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	14.80	16.01	[a] APO-Fluoxetine [TX]	[a] Auscap Aspen [RW]
					[a] Blooms the Chemist Fluoxetine [IB]	[a] Chem mart Fluoxetine [CH]
					[a] FLUOTEX [RF]	[a] Fluoxetine AN [EA]
					[a] Fluoxetine-GA [ED]	[a] Fluoxetine generichealth [GQ]
					[a] Fluoxetine Sandoz [SZ]	[a] GenRx Fluoxetine [GX]
					[a] Lovan [AL]	[a] Terry White Chemists Fluoxetine [TW]
					[a] Zactin [AF]	
		[B]1.18	15.98	16.01	[a] Prozac 20 [LY]	

▪ FLUVOXAMINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

fluvoxamine maleate 50 mg tablet, 30

8512B (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	16.75	17.96	[a] APO-Fluvoxamine [TX]	[a] Faverin 50 [RW]
					[a] Fluvoxamine AN [ED]	[a] Fluvoxamine GA [EA]
					[a] Movox 50 [AL]	[a] Voxam [SZ]
		[B]3.50	20.25	17.96	[a] Luvox [GO]	

fluvoxamine maleate 100 mg tablet, 30

8174F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.66	20.87	[a] APO-Fluvoxamine [TX] [a] Fluvoxamine AN [ED] [a] Movox 100 [AF]	[a] Faverin 100 [RW] [a] Fluvoxamine GA [EA] [a] Voxam [SZ]
			[B]3.50	23.16	20.87	[a] Luvox [GO]	

▪ PAROXETINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Panic disorder

paroxetine 20 mg tablet, 30

2242B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.51	15.72	[a] APO-Paroxetine [TX] [a] Extine 20 [RW] [a] Paroxetine AN [EA] [a] Paroxetine Sandoz [SZ] [a] Roxet 20 [DO]	[a] Chem mart Paroxetine [CH] [a] GenRx Paroxetine [GX] [a] Paroxetine GH [GQ] [a] Paxtine [AF] [a] Terry White Chemists Paroxetine [TW]
			[B]2.58	17.09	15.72	[a] Aropax [AS]	

▪ SERTRALINE

Restricted benefit

Major depressive disorders

sertraline 100 mg tablet, 30

2237R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.78	13.99	[a] APO-Sertraline [TX] [a] Chem mart Sertraline [CH] [a] Sertra 100 [RW] [a] Sertraline AN [EA] [a] Sertraline Sandoz [SZ] [a] Terry White Chemists Sertraline [TW]	[a] Auro-Sertraline 100 [DO] [a] Eleva 100 [AF] [a] Sertracor 100 [CR] [a] Sertraline generichealth [GQ] [a] Setrona [RA]
			[B]5.80	18.58	13.99	[a] Zoloft [PF]	

sertraline 50 mg tablet, 30

2236Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.78	13.99	[a] APO-Sertraline [TX] [a] Chem mart Sertraline [CH] [a] Sertra 50 [RW] [a] Sertraline AN [EA] [a] Sertraline Sandoz [SZ] [a] Terry White Chemists Sertraline [TW]	[a] Auro-Sertraline 50 [DO] [a] Eleva 50 [AF] [a] Sertracor 50 [CR] [a] Sertraline generichealth [GQ] [a] Setrona [RA]
			[B]5.80	18.58	13.99	[a] Zoloft [PF]	

▪ SERTRALINE

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Panic disorder

Clinical criteria:

- The treatment must be for use when other treatments have failed; OR
- The treatment must be for use when other treatments are inappropriate.

sertraline 100 mg tablet, 30

8837D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.78	13.99	[a] Auro-Sertraline 100 [DO] [a] Sertraline AN [EA]	[a] Eleva 100 [AF]
			[B]5.80	18.58	13.99	[a] Zoloft [PF]	

sertraline 50 mg tablet, 30

8836C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.78	13.99	[a] Auro-Sertraline 50 [DO]	[a] Eleva 50 [AF]

				[a] Sertraline AN [EA]
[B]5.80	18.58	13.99	[a] Zoloft [PF]	

Monoamine oxidase inhibitors, non-selective

▪ PHENELZINE

Caution This drug is an irreversible monoamine oxidase inhibitor.

Restricted benefit

Depression

Clinical criteria:

- The treatment must be for when all other anti-depressant therapy has failed; OR
- The treatment must be for when all other anti-depressant therapy is inappropriate.

phenelzine 15 mg tablet, 100

2856H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	91.99	39.50	Nardil [LM]

▪ TRANYLCYPROMINE

Caution This drug is an irreversible monoamine oxidase inhibitor.

tranylcypromine 10 mg tablet, 50

2444P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	55.92	39.50	Parnate [GH]

Monoamine oxidase A inhibitors

▪ MOCLOBEMIDE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Major depressive disorders

moclobemide 150 mg tablet, 60

1900B

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	20.83	22.04	[a] Amira 150 [AF] [a] GenRx Moclobemide [GX] [a] Moclobemide Sandoz [SZ]	[a] Clobemix [ED] [a] Moclobemide AN [EA] [a] Mohexal [HX]
		[B]3.00	23.83	22.04	[a] Aurorix [HM]	

moclobemide 300 mg tablet, 60

8003F

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	27.36	28.57	[a] Amira 300 [AF] [a] GenRx Moclobemide [GX] [a] Moclobemide Sandoz [SZ]	[a] Clobemix [ED] [a] Moclobemide AN [EA]
		[B]3.00	30.36	28.57	[a] Aurorix 300 mg [HM]	

Other antidepressants

▪ DESVENLAFAXINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note Pharmaceutical benefits that have the forms desvenlafaxine tablet (modified release) 50 mg, desvenlafaxine tablet (modified release) 50 mg (as benzoate) and desvenlafaxine tablet (extended release) 50 mg (as succinate) are equivalent for the purposes of substitution.

Note Pharmaceutical benefits that have the forms desvenlafaxine tablet (modified release) 100 mg, desvenlafaxine tablet (modified release) 100 mg (as benzoate) and desvenlafaxine tablet (extended release) 100 mg (as succinate) are equivalent for the purposes of substitution.

Restricted benefit

Major depressive disorders

desvenlafaxine 50 mg modified release tablet, 28

10234P

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	25.36	26.57	[a] APO-Desvenlafaxine MR [TX]	[a] Desvenlafaxine GH XR [GQ]

desvenlafaxine 50 mg modified release tablet, 28

10241B

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	25.36	26.57	[a] Desfax [AF]	[a] DESVEN [RW]

						[a] Desvenlafaxine Actavis [EA]	[a] Desvenlafaxine Sandoz [SZ]

desvenlafaxine 50 mg modified release tablet, 28

9366Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	
NP	1	5	..	25.36	26.57	[a] Pristiq [PF]	

desvenlafaxine 100 mg modified release tablet, 28

10231L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.61	29.82	[a] Desfax [AF] [a] Desvenlafaxine Actavis [EA]	[a] DESVEN [RW] [a] Desvenlafaxine Sandoz [SZ]

desvenlafaxine 100 mg modified release tablet, 28

10245F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.61	29.82	[a] APO-Desvenlafaxine MR [TX]	[a] Desvenlafaxine GH XR [GQ]

desvenlafaxine 100 mg modified release tablet, 28

9367B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	28.61	29.82	[a] Pristiq [PF]

▪ DULOXETINE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Major depressive disorders

duloxetine 30 mg enteric capsule, 28

9155W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	15.24	16.45	[a] Andepra [EL] [a] Chem mart Duloxetine [CH] [a] Duloxetine AN [EA] [a] Pharmacor Duloxetine 30 [CR] [a] Tixol [AL]	[a] APO-Duloxetine [TX] [a] Depreta 30 [DO] [a] DYTREX 30 [RW] [a] Terry White Chemists Duloxetine [TW]
			[B]1.90	17.14	16.45	[a] Cymbalta [LY]	

duloxetine 60 mg enteric capsule, 28

9156X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.01	18.22	[a] Andepra [EL] [a] Chem mart Duloxetine [CH] [a] Duloxetine AN [EA] [a] Pharmacor Duloxetine 60 [CR] [a] Tixol [AL]	[a] APO-Duloxetine [TX] [a] Depreta 60 [DO] [a] DYTREX 60 [RW] [a] Terry White Chemists Duloxetine [TW]
			[B]1.91	18.92	18.22	[a] Cymbalta [LY]	

▪ LITHIUM CARBONATE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lithium carbonate 450 mg modified release tablet, 100

8290H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*35.57	36.78	Quilonum SR [AS]

lithium carbonate 250 mg tablet, 200

3059B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	23.19	24.40	Lithicarb [AS]

▪ MIANSERIN

Caution Neutropenia and agranulocytosis are more frequent in the elderly, especially in the early months of therapy.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Severe depression

mianserin hydrochloride 20 mg tablet, 50

1628Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	27.54	28.75	Lumin 20 [AF]

mianserin hydrochloride 10 mg tablet, 50

1627P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	18.89	20.10	Lumin 10 [AF]

▪ MIRTAZAPINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Major depressive disorders

mirtazapine 30 mg tablet, 30

8513C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.69	15.90	[a] APO-Mirtazapine [TX] [a] Axit 30 [AF] [a] MIRTANZA [RF] [a] Mirtazapine GH [GQ] [a] Mirtazon [RW]	[a] Aurozapine 30 [DO] [a] Chem mart Mirtazapine [CH] [a] Mirtazapine AN [EA] [a] Mirtazapine Sandoz [SZ] [a] Terry White Chemists Mirtazapine [TW]
			[B]5.00	19.69	15.90	[a] Avanza [MK]	

mirtazapine 15 mg tablet, 30

9365X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.49	14.70	[a] APO-Mirtazapine [TX] [a] MIRTANZA [RF]	[a] Axit 15 [AF] [a] Mirtazapine AN [EA]

mirtazapine 45 mg tablet, 30

8883M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.09	18.30	[a] APO-Mirtazapine [TX] [a] Axit 45 [AF] [a] MIRTANZA [RF] [a] Mirtazapine GH [GQ] [a] Mirtazon [RW]	[a] Aurozapine 45 [DO] [a] Chem mart Mirtazapine [CH] [a] Mirtazapine AN [EA] [a] Mirtazapine Sandoz [SZ] [a] Terry White Chemists Mirtazapine [TW]

MIRTAZAPINE Tablet 15 mg (orally disintegrating), 30

8855C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.23	16.44	[a] Milivin OD 15 [DO] [a] Mirtazapine Sandoz ODT 15 [SZ]	[a] Mirtazapine AN ODT [EA]
			[B]4.75	19.98	16.44	[a] Avanza SolTab [MK]	[a] Remeron SolTab [AF]

MIRTAZAPINE Tablet 45 mg (orally disintegrating), 30

8857E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.39	20.60	[a] Milivin OD 45 [DO] [a] Mirtazapine Sandoz ODT 45 [SZ]	[a] Mirtazapine AN ODT [EA]
			[B]4.75	24.14	20.60	[a] Avanza SolTab [MK]	[a] Remeron SolTab [AF]

MIRTAZAPINE Tablet 30 mg (orally disintegrating), 30

8856D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.61	17.82	[a] Milivin OD 30 [DO] [a] Mirtazapine Sandoz ODT 30 [SZ]	[a] Mirtazapine AN ODT [EA]
			[B]4.75	21.36	17.82	[a] Avanza SolTab [MK]	[a] Remeron SolTab [AF]

▪ REBOXETINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Major depressive disorders

reboxetine 4 mg tablet, 60

8583R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	37.80	39.01	Edronax [PF]

▪ VENLAFAXINE

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Major depressive disorders

venlafaxine 37.5 mg modified release capsule, 28

8868R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.48	14.69	[a] Efexor-XR [PF] [a] Venlafaxine AN SR [EA]	[a] Elaxine SR 37.5 [ZP]

venlafaxine 150 mg modified release capsule, 28

8302Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.48	16.69	[a] APO-Venlafaxine XR [TX]	[a] Blooms the Chemist Venlafaxine XR [IB]
						[a] Chem mart Venlafaxine XR [CH]	[a] Efexor-XR [PF]
						[a] Elaxine SR 150 [ZP]	[a] Enlafax-XR [AF]
						[a] Sandoz Venlafaxine XR [HX]	[a] Terry White Chemists Venlafaxine XR [TW]
						[a] Venlafaxine AN SR [EA]	[a] Venlafaxine generichealth XR [GQ]
						[a] Venlafaxine Sandoz XR [SZ]	[a] Venla RBX [RA]

venlafaxine 75 mg modified release capsule, 28

8301X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.69	15.90	[a] APO-Venlafaxine XR [TX]	[a] Blooms the Chemist Venlafaxine XR [IB]
						[a] Chem mart Venlafaxine XR [CH]	[a] Efexor-XR [PF]
						[a] Elaxine SR 75 [ZP]	[a] Enlafax-XR [AF]
						[a] Sandoz Venlafaxine XR [HX]	[a] Terry White Chemists Venlafaxine XR [TW]
						[a] Venlafaxine AN SR [EA]	[a] Venlafaxine generichealth XR [GQ]
						[a] Venlafaxine Sandoz XR [SZ]	

PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS

Centrally acting sympathomimetics

▪ ARMODAFINIL

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note This drug is not PBS-subsidised when used in combination with PBS-subsidised dexamphetamine sulphate or modafinil.

Authority required

Narcolepsy

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a qualified sleep medicine practitioner or neurologist.

Clinical criteria:

- The treatment must be for use when therapy with dexamphetamine sulfate poses an unacceptable medical risk; OR
- The treatment must be for use when intolerance to dexamphetamine sulfate is of a severity to necessitate treatment withdrawal, **AND**
- Patient must have experienced excessive daytime sleepiness, recurrent naps or lapses into sleep occurring almost daily for at least 3 months, **AND**

- Patient must have a definite history of cataplexy; OR
- Patient must have a mean sleep latency less than or equal to 10 minutes on a Multiple Sleep Latency Test (MSLT); OR
- Patient must have an electroencephalographic (EEG) recording showing the pathologically rapid development of REM sleep, **AND**
- Patient must not have any medical or psychiatric disorder that could otherwise account for the hypersomnia.

The presence of any one of the following indicates treatment with dexamphetamine sulfate poses an unacceptable medical risk:

(a) a psychiatric disorder;

(b) a cardiovascular disorder;

(c) a history of substance abuse;

(d) glaucoma;

(e) any other absolute contraindication to dexamphetamine sulfate as specified in the TGA-approved Product Information.

The MSLT must be preceded by nocturnal polysomnography. Sleep prior to the MSLT must be at least 6 hours in duration.

The authority application must be made in writing and must include the following:

(a) a completed authority prescription form; and

(b) a completed Narcolepsy Initial PBS authority application and Supporting information form; and

(c) details of the contraindication or intolerance to dexamphetamine sulfate; and

(d) either:

(i) the result and date of the polysomnography test and Multiple Sleep Latency Test (MSLT) conducted by, or under the supervision of, a qualified sleep medicine practitioner; or

(ii) the result and date of the electroencephalograph (EEG), conducted by, or under the supervision of, a neurologist.

The polysomnography, MSLT or EEG test reports must be provided with the authority application.

Authority required

Narcolepsy

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

armodafinil 50 mg tablet, 30

10922W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*105.93	39.50	Nuvigil [TB]

armodafinil 150 mg tablet, 30

10912H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	153.34	39.50	Nuvigil [TB]

armodafinil 250 mg tablet, 30

10919Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	250.17	39.50	Nuvigil [TB]

▪ ATOMOXETINE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4578

Attention deficit hyperactivity disorder

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug.

Authority required (STREAMLINED)

6279

Attention deficit hyperactivity disorder

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be or have been diagnosed by a paediatrician or psychiatrist according to the DSM-5 criteria, **AND**
- Patient must have a contraindication to dexamphetamine, methylphenidate or lisdexamfetamine as specified in TGA-approved product information; OR
- Patient must have a comorbid mood disorder that has developed or worsened as a result of dexamphetamine, methylphenidate or lisdexamfetamine treatment and is of a severity necessitating treatment withdrawal; OR
- Patient must be at an unacceptable medical risk of a severity necessitating permanent stimulant treatment withdrawal if given a stimulant treatment with another agent; OR
- Patient must have experienced adverse reactions of a severity necessitating permanent treatment withdrawal following treatment with dexamphetamine, methylphenidate and lisdexamfetamine (not simultaneously).

Population criteria:

- Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

atomoxetine 10 mg capsule, 28

9092M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*168.11	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

▪ ATOMOXETINE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
6279
Attention deficit hyperactivity disorder
Treatment Phase: Initial treatment
Clinical criteria:

- The condition must be or have been diagnosed by a paediatrician or psychiatrist according to the DSM-5 criteria, **AND**
- Patient must have a contraindication to dexamphetamine, methylphenidate or lisdexamfetamine as specified in TGA-approved product information; OR
- Patient must have a comorbid mood disorder that has developed or worsened as a result of dexamphetamine, methylphenidate or lisdexamfetamine treatment and is of a severity necessitating treatment withdrawal; OR
- Patient must be at an unacceptable medical risk of a severity necessitating permanent stimulant treatment withdrawal if given a stimulant treatment with another agent; OR
- Patient must have experienced adverse reactions of a severity necessitating permanent treatment withdrawal following treatment with dexamphetamine, methylphenidate and lisdexamfetamine (not simultaneously).

Population criteria:

- Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

Authority required (STREAMLINED)
4578
Attention deficit hyperactivity disorder
Treatment Phase: Continuing treatment
Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug.

atomoxetine 18 mg capsule, 28

9093N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*168.11	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

atomoxetine 25 mg capsule, 28

9094P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*168.11	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

atomoxetine 100 mg capsule, 28

9290Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	113.15	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

atomoxetine 60 mg capsule, 28

9096R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*168.11	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

atomoxetine 40 mg capsule, 28

9095Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*168.11	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

atomoxetine 80 mg capsule, 28

9289X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	113.15	39.50	[a] APO-Atomoxetine [TX] [a] Atomoxetine Amneal [EA] [a] Strattera [LY]	[a] ATOMERRA [RW] [a] Atomoxetine Sandoz [SZ]

▪ DEXAMFETAMINE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Attention deficit hyperactivity disorder

Treatment must be in accordance with the law of the relevant State or Territory.

Authority required

Narcolepsy

dexamfetamine sulfate 5 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1165H NP	1	5	..	21.58	22.79	Aspen Pharma Pty Ltd [QA]

▪ LISDEXAMFETAMINE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Attention deficit hyperactivity disorder

Clinical criteria:

- Patient must require continuous coverage over 12 hours.

Population criteria:

- Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

lisdexamfetamine dimesilate 50 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10474G NP	1	5	..	117.10	39.50	Vyvanse [ZI]

lisdexamfetamine dimesilate 70 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10492F NP	1	5	..	117.10	39.50	Vyvanse [ZI]

lisdexamfetamine dimesilate 30 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10486X NP	1	5	..	117.10	39.50	Vyvanse [ZI]

▪ METHYLPHENIDATE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Attention deficit hyperactivity disorder

Population criteria:

- Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

Clinical criteria:

- Patient must have demonstrated a response to immediate-release methylphenidate hydrochloride with no emergence of serious adverse events, **AND**
- Patient must require continuous coverage over 12 hours.

methylphenidate hydrochloride 27 mg modified release tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2172H NP	1	5	..	55.93	39.50	Concerta [JC]

methylphenidate hydrochloride 18 mg modified release tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2387P NP	1	5	..	51.79	39.50	Concerta [JC]

methylphenidate hydrochloride 54 mg modified release tablet, 30

2432B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	69.21	39.50	Concerta [JC]

methylphenidate hydrochloride 36 mg modified release tablet, 30

2388Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	60.06	39.50	Concerta [JC]

▪ METHYLPHENIDATE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Attention deficit hyperactivity disorder

Population criteria:

- Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

Clinical criteria:

- Patient must have demonstrated a response to immediate-release methylphenidate hydrochloride with no emergence of serious adverse events, **AND**
- Patient must require continuous coverage over 8 hours.

methylphenidate hydrochloride 30 mg modified release capsule, 30

2280B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	52.50	39.50	Ritalin LA [NV]

methylphenidate hydrochloride 20 mg modified release capsule, 30

2276T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	45.04	39.50	Ritalin LA [NV]

methylphenidate hydrochloride 40 mg modified release capsule, 30

2283E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	55.03	39.50	Ritalin LA [NV]

methylphenidate hydrochloride 10 mg modified release capsule, 30

3440C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	35.77	36.98	Ritalin LA [NV]

▪ METHYLPHENIDATE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Continuing Therapy Only:
For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Attention deficit hyperactivity disorder

Treatment must be in accordance with the law of the relevant State or Territory.

methylphenidate hydrochloride 10 mg tablet, 100

8839F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.24	24.45	[a] Artige [NM]	[a] Ritalin 10 [NV]

▪ MODAFINIL

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note This drug is not PBS-subsidised when used in combination with PBS-subsidised dexamphetamine sulphate or armodafinil.

Authority required

Narcolepsy

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a qualified sleep medicine practitioner or neurologist.

Clinical criteria:

- The treatment must be for use when therapy with dexamphetamine sulfate poses an unacceptable medical risk; OR
- The treatment must be for use when intolerance to dexamphetamine sulfate is of a severity to necessitate treatment withdrawal, **AND**
- Patient must have experienced excessive daytime sleepiness, recurrent naps or lapses into sleep occurring almost daily for at least 3 months, **AND**
- Patient must have a definite history of cataplexy; OR
- Patient must have a mean sleep latency less than or equal to 10 minutes on a Multiple Sleep Latency Test (MSLT); OR
- Patient must have an electroencephalographic (EEG) recording showing the pathologically rapid development of REM sleep, **AND**
- Patient must not have any medical or psychiatric disorder that could otherwise account for the hypersomnia.

The presence of any one of the following indicates treatment with dexamphetamine sulfate poses an unacceptable medical risk:

(a) a psychiatric disorder;

(b) a cardiovascular disorder;

(c) a history of substance abuse;

(d) glaucoma;

(e) any other absolute contraindication to dexamphetamine sulfate as specified in the TGA-approved Product Information.

The MSLT must be preceded by nocturnal polysomnography. Sleep prior to the MSLT must be at least 6 hours in duration.

The authority application must be made in writing and must include the following:

(a) a completed authority prescription form; and

(b) a completed Narcolepsy Initial PBS authority application and Supporting information form; and

(c) details of the contraindication or intolerance to dexamphetamine sulfate; and

(d) either:

(i) the result and date of the polysomnography test and Multiple Sleep Latency Test (MSLT) conducted by, or under the supervision of, a qualified sleep medicine practitioner; or

(ii) the result and date of the electroencephalograph (EEG), conducted by, or under the supervision of, a neurologist.

The polysomnography, MSLT or EEG test reports must be provided with the authority application.

Authority required

Narcolepsy

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

modafinil 100 mg tablet, 60

8816B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*285.23	39.50	[a] APO-Modafinil [TX] [a] Modafinil AN [EA] [a] Modafinil Sandoz [SZ]	[a] Modafin [RW] [a] Modafinil Mylan [AF] [a] Modavigil [TB]

ANTI-DEMENTIA DRUGS

Anticholinesterases

▪ DONEPEZIL

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

- Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**
- Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

donepezil hydrochloride 5 mg tablet, 28

2532G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.15	22.36	[a] APO-Donepezil [TX] [a] Aridon 5 [RW] [a] Chem mart Donepezil [CH] [a] Donepezil-DRLA [RZ] [a] Donepezil Sandoz [SZ]	[a] Arazil [AF] [a] Aridon APN 5 [RF] [a] Donepezil AN [EA] [a] Donepezil generichealth [GQ] [a] Terry White Chemists Donepezil [TW]
			[B]3.68	24.83	22.36	[a] Aricept [PF]	

donepezil hydrochloride 10 mg tablet, 28

2479L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.15	22.36	[a] APO-Donepezil [TX] [a] Aridon 10 [RW] [a] Chem mart Donepezil [CH] [a] Donepezil-DRLA [RZ] [a] Donepezil RBX [RA] [a] Pharmacor Donepezil 10 [CR]	[a] Arazil [AF] [a] Aridon APN 10 [RF] [a] Donepezil AN [EA] [a] Donepezil generichealth [GQ] [a] Donepezil Sandoz [SZ] [a] Terry White Chemists Donepezil [TW]
			[B]9.00	30.15	22.36	[a] Aricept [PF]	

▪ DONEPEZIL

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

(1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;

(2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;

(3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;

(4) Intellectual (developmental or acquired) disability, eg Down's syndrome;

(5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;

(6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

donepezil hydrochloride 5 mg tablet, 28

8495D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.15	22.36	[a] APO-Donepezil [TX] [a] Aridon 5 [RW] [a] Chem mart Donepezil [CH] [a] Donepezil-DRLA [RZ] [a] Donepezil Sandoz [SZ]	[a] Arazil [AF] [a] Aridon APN 5 [RF] [a] Donepezil AN [EA] [a] Donepezil generichealth [GQ] [a] Terry White Chemists Donepezil [TW]
			[B]3.68	24.83	22.36	[a] Aricept [PF]	

donepezil hydrochloride 10 mg tablet, 28

8496E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.15	22.36	[a] APO-Donepezil [TX] [a] Aridon 10 [RW] [a] Chem mart Donepezil [CH] [a] Donepezil-DRLA [RZ] [a] Donepezil RBX [RA] [a] Pharmacor Donepezil 10 [CR]	[a] Arazil [AF] [a] Aridon APN 10 [RF] [a] Donepezil AN [EA] [a] Donepezil generichealth [GQ] [a] Donepezil Sandoz [SZ] [a] Terry White Chemists Donepezil [TW]
			[B]9.00	30.15	22.36	[a] Aricept [PF]	

▪ GALANTAMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

- Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**
- Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

galantamine 8 mg modified release capsule, 28

2463P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.97	34.18	[a] APO-Galantamine MR [TX] [a] Galantyl [AF] [a] Reminyl [JC]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

galantamine 16 mg modified release capsule, 28

2537M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	37.85	39.06	[a] APO-Galantamine MR [TX] [a] Galantyl [AF] [a] Reminyl [JC]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

galantamine 24 mg modified release capsule, 28

2531F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.98	39.50	[a] APO-Galantamine MR [TX] [a] Galantyl [AF]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

[a] Reminyl [JC]

▪ GALANTAMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

(1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;

(2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;

(3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;

(4) Intellectual (developmental or acquired) disability, eg Down's syndrome;

(5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;

(6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

galantamine 8 mg modified release capsule, 28

8770N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.97	34.18	[a] APO-Galantamine MR [TX] [a] Galantyl [AF] [a] Reminyl [JC]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

galantamine 16 mg modified release capsule, 28

8771P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	37.85	39.06	[a] APO-Galantamine MR [TX] [a] Galantyl [AF] [a] Reminyl [JC]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

galantamine 24 mg modified release capsule, 28

8772Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.98	39.50	[a] APO-Galantamine MR [TX] [a] Galantyl [AF]	[a] Galantamine AN SR [EA] [a] Gamine XR [RW]

[a] Reminyl [JC]

▪ RIVASTIGMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

- Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**
- Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

rivastigmine 4.5 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2494G NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 4.6 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2477J NP	1	5	..	80.59	39.50	[a] Exelon Patch 5 [NV]	[a] Rivastigmelon Patch 5 [AF]

rivastigmine 13.3 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10538P NP	1	5	..	80.59	39.50	Exelon Patch 15 [NV]

rivastigmine 1.5 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2475G NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 6 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2526Y NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 9.5 mg/24 hours patch, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2551G NP	1	5	..	80.59	39.50	[a] Exelon Patch 10 [NV]	[a] Rivastigmelon Patch 10 [AF]

rivastigmine 3 mg capsule, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2493F NP	1	5	..	88.31	39.50	Exelon [NV]

▪ RIVASTIGMINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**

- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

(1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;

(2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;

(3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;

(4) Intellectual (developmental or acquired) disability, eg Down's syndrome;

(5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;

(6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

rivastigmine 4.5 mg capsule, 56

8499H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 4.6 mg/24 hours patch, 30

9161E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	80.59	39.50	[a] Exelon Patch 5 [NV]	[a] Rivastigmelon Patch 5 [AF]

rivastigmine 13.3 mg/24 hours patch, 30

10541T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	80.59	39.50	Exelon Patch 15 [NV]

rivastigmine 1.5 mg capsule, 56

8497F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 6 mg capsule, 56

8500J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	88.31	39.50	Exelon [NV]

rivastigmine 9.5 mg/24 hours patch, 30

9162F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	80.59	39.50	[a] Exelon Patch 10 [NV]	[a] Rivastigmelon Patch 10 [AF]

rivastigmine 3 mg capsule, 56

8498G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	88.31	39.50	Exelon [NV]

Other anti-dementia drugs

▪ MEMANTINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

4214

Moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

- Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**
- Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

memantine hydrochloride 10 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2492E NP	1	5	..	41.29	39.50	[a] APO-Memantine [TX] [a] Memantine generichealth [GQ]	[a] Ebixa [LU] [a] Memanxa [RW]

memantine hydrochloride 20 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2513G NP	1	5	..	41.29	39.50	[a] APO-Memantine [TX] [a] Memantine generichealth [GQ]	[a] Ebixa [LU]

▪ MEMANTINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 to 14, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE of 10 to 14.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

- Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**
- The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 to 14 for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

(1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;

(2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;

(3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;

(4) Intellectual (developmental or acquired) disability, eg Down's syndrome;

(5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;

(6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

memantine hydrochloride 10 mg tablet, 56

1956Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	41.29	39.50	[a] APO-Memantine [TX] [a] Memantine generichealth [GQ]	[a] Ebixa [LU] [a] Memanxa [RW]

memantine hydrochloride 20 mg tablet, 28

9306T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	41.29	39.50	[a] APO-Memantine [TX] [a] Memantine generichealth [GQ]	[a] Ebixa [LU]

OTHER NERVOUS SYSTEM DRUGS

PARASYMPATHOMIMETICS

Anticholinesterases

PYRIDOSTIGMINE

PYRIDOSTIGMINE BROMIDE Tablet 10 mg, 50

2724J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*24.79	26.00	Mestinon [IA]

pyridostigmine bromide 180 mg modified release tablet, 50

2608G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*134.41	39.50	Mestinon Timespan [IA]

pyridostigmine bromide 60 mg tablet, 150

1959D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	67.14	39.50	Mestinon [IA]

Choline esters

BETHANECHOL

bethanechol chloride 10 mg tablet, 100

1062X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	37.92	39.13	Uro-Carb [YN]

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in nicotine dependence

BUPROPION

Note Clinical review is recommended within 2 to 3 weeks of the original prescription being requested.
Note The period between commencing a course of bupropion hydrochloride and varenicline tartrate must be at least 6 months.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6881

Nicotine dependence

Treatment Phase: Completion of a short-term (9 weeks) course of treatment

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug during this current course of treatment, **AND**
- Patient must not receive more than 9 weeks of PBS-subsidised treatment with this drug per 12-month period.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program.

bupropion hydrochloride 150 mg modified release tablet, 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8710K NP	1	..	..	165.40	39.50	Zyban [AS]

▪ BUPROPION

Note Clinical review is recommended within 2 to 3 weeks of the original prescription being requested.

Note The period between commencing a course of bupropion hydrochloride and varenicline tartrate must be at least 6 months.

Note A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6882

Nicotine dependence

Treatment Phase: Commencement of a short-term (9 weeks) course of treatment

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have indicated they are ready to cease smoking, **AND**
- Patient must not receive more than 9 weeks of PBS-subsidised treatment with this drug per 12-month period.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program or is about to enter such a program at the time PBS-subsidised treatment is initiated.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

bupropion hydrochloride 150 mg modified release tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8465M NP	1	..	..	62.53	39.50	Zyban [AS]

▪ NICOTINE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Nicotine dependence

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have indicated they are ready to cease smoking, **AND**
- Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program or is about to enter such a program at the time PBS-subsidised treatment is initiated.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

nicotine 21 mg/24 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3414Q NP	1	2	..	53.17	39.50	Nicotinell Step 1 [ON]

nicotine 14 mg/24 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5572G NP	1	2	..	53.17	39.50	Nicotinell Step 2 [ON]

nicotine 7 mg/24 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5573H NP	1	2	..	53.17	39.50	Nicotinell Step 3 [ON]

▪ NICOTINE

Note Only 2 courses of PBS-subsidised nicotine replacement therapy may be prescribed per 12-month period. Benefit is improved if used in conjunction with a comprehensive support and counselling program.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Nicotine dependence

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition.

nicotine 21 mg/24 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5571F NP	1	2	..	53.17	39.50	Nicotinell Step 1 [ON]

▪ NICOTINE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Nicotine dependence

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition.

Note Only 2 courses of PBS-subsidised nicotine replacement therapy may be prescribed per 12-month period. Benefit is improved if used in conjunction with a comprehensive support and counselling program.

Restricted benefit

Nicotine dependence

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have indicated they are ready to cease smoking, **AND**
- Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program or is about to enter such a program at the time PBS-subsidised treatment is initiated.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

nicotine 21 mg/24 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5465P NP	1	2	..	53.17	39.50	Nicabate P [GC]

nicotine 25 mg/16 hours patch, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10076H NP	1	2	..	53.17	39.50	nicorette 16hr Invisipatch [JT]

▪ VARENICLINE

Note A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.

Note A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6885

Nicotine dependence

Treatment Phase: Completion of a short-term (24 weeks) course of treatment

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug during this current course of treatment, **AND**
- Patient must have ceased smoking in the process of completing an initial 12-weeks or ceased smoking following an initial 12-weeks of PBS-subsidised treatment with this drug in the current course of treatment.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program.

varenicline 1 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5469W NP	1	2	..	109.55	39.50	Champix [PF]

▪ VARENICLINE

Note A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.
Note A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6864

Nicotine dependence

Treatment Phase: Continuation of a short-term (12 weeks or 24 weeks) course of treatment

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug during this current course of treatment.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program.

varenicline 1 mg tablet, 56

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9129L NP	2	..	..	*208.61	39.50	Champix [PF]

▪ VARENICLINE

Note A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.
Note The period between commencing varenicline and bupropion or a new course of varenicline must be at least 6 months.
Note A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6871

Nicotine dependence

Treatment Phase: Commencement of a short-term (12 weeks or 24 weeks) course of treatment

Clinical criteria:

- The treatment must be as an aid to achieving abstinence from smoking, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have indicated they are ready to cease smoking, **AND**
- Patient must not receive more than 24 weeks of PBS-subsidised treatment with this drug per 12-month period.

Treatment criteria:

- Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program or is about to enter such a program at the time PBS-subsidised treatment is initiated.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Clinical review is recommended within 2 to 3 weeks of the initial prescription being requested.

varenicline 500 microgram tablet [11 tablets] (&) varenicline 1 mg tablet [42 tablets], 53

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9128K NP	‡1	..	..	94.60	39.50	Champix [PF]

Drugs used in alcohol dependence

▪ ACAMPROSATE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

5366

Alcohol dependence

Clinical criteria:

- The treatment must be part of a comprehensive treatment program with the goal of maintaining abstinence.

acamprosate calcium 333 mg enteric tablet, 180

8357W NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	149.41	39.50	Campral [AF]

▪ NALTREXONE

Caution Naltrexone hydrochloride is contraindicated in patients receiving opioid drugs.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Alcohol dependence

Clinical criteria:

- The treatment must be part of a comprehensive treatment program with the goal of maintaining abstinence.

naltrexone hydrochloride 50 mg tablet, 30

8370M NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	1	..	128.59	39.50	[a] APO-Naltrexone [TX] [a] ReVia [BQ]	[a] Naltrexone GH [GQ]

OTHER NERVOUS SYSTEM DRUGS

Other nervous system drugs

▪ DIMETHYL FUMARATE

Note Special Pricing Arrangements apply.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

dimethyl fumarate 120 mg enteric capsule, 14

2943X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	..	..	*969.23	39.50	Tecfidera [BD]

▪ DIMETHYL FUMARATE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

dimethyl fumarate 240 mg enteric capsule, 56

2966D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1871.14	39.50	Tecfidera [BD]

▪ DIMETHYL FUMARATE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

dimethyl fumarate 120 mg enteric capsule, 14

2896K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	..	..	*969.23	39.50	Tecfidera [BD]

▪ RILUZOLE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Amyotrophic lateral sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed by a neurologist, **AND**
- Patient must not have had the disease for more than 5 years, **AND**
- Patient must have at least 60 percent of predicted forced vital capacity within the 2 months before commencing therapy with this drug, **AND**
- Patient must be ambulatory; OR
- Patient must not be ambulatory, and must be able to either use upper limbs or to swallow, **AND**
- Patient must not have undergone a tracheostomy, **AND**
- Patient must not have experienced respiratory failure.

The date of diagnosis and the date and results of spirometry (in terms of percent of predicted forced vital capacity) must be supplied with the initial authority application.

Authority required

Amyotrophic lateral sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must be ambulatory; OR
- Patient must not be ambulatory, and must be able to either use upper limbs or to swallow, **AND**
- Patient must not have undergone a tracheostomy, **AND**
- Patient must not have experienced respiratory failure.

riluzole 50 mg tablet, 56

8664B

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	203.32	39.50	[a] APO-Riluzole [TX] [a] Rilutek [SW]	[a] Pharmacor Riluzole [CR] [a] Riluzole Sandoz [SZ]

▪ TETRABENAZINE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5340

Hyperkinetic extrapyramidal disorders

tetrabenazine 25 mg tablet, 112

1330B

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	338.60	39.50	iNova Pharmaceuticals (Australia) Pty Ltd [IA]

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

ANTIPROTOZOALS

AGENTS AGAINST AMOEBIASIS AND OTHER PROTOZOAL DISEASES

Other agents against amoebiasis and other protozoal diseases

ATOVAQUONE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)
5609
Mild to moderate Pneumocystis carinii pneumonia
Population criteria:
- Patient must be an adult, **AND**
- Patient must be intolerant of trimethoprim/sulfamethoxazole therapy.

atovaquone 750 mg/5 mL oral liquid, 210 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8300W NP	‡1	..	..	976.85	39.50	Wellvone [AS]

PYRIMETHAMINE

pyrimethamine 25 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1966L NP	1	..	..	19.32	20.53	Daraprim [RW]

ANTIMALARIALS

Biguanides

ATOVAQUONE + PROGUANIL

Note This drug is not PBS-subsidised for prophylaxis of malaria.
Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit
Confirmed or suspected Plasmodium falciparum malaria
Population criteria:
- Patient must be aged 3 years or older.

Clinical criteria:
- The treatment must be used where quinine containing regimens are inappropriate.

atovaquone 250 mg + proguanil hydrochloride 100 mg tablet, 12

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9439T NP	1	..	..	66.16	39.50	Malarone [GK]

Methanolquinolines

QUININE

Caution Severe thrombocytopenia has been reported with this drug.
Authority required (STREAMLINED)
5633
Malaria

quinine sulfate 300 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1975Y NP	1	2	..	19.91	21.12	Quinate [RW]

Artemisinin and derivatives, combinations

ARTEMETHER + LUMEFANTRINE

Note This drug is not PBS-subsidised for prophylaxis of malaria.

Restricted benefit
Confirmed or suspected Plasmodium falciparum malaria
Clinical criteria:
- Patient must be unable to swallow a solid dosage form of artemether with lumefantrine.

artemether 20 mg + lumefantrine 120 mg dispersible tablet, 18

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5296R	1	..	..	89.24	39.50	Riamet 20mg/120mg Dispersible [SZ]

▪ ARTEMETHER + LUMEFANTRINE

Note This drug is not PBS-subsidised for prophylaxis of malaria.

Restricted benefit

Confirmed or suspected Plasmodium falciparum malaria

artemether 20 mg + lumefantrine 120 mg tablet, 24

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9498X	1	..	..	89.24	39.50	Riamet [SZ]

▪ ANTHELMINTICS

ANTITREMATODALS

Quinoline derivatives and related substances

▪ PRAZIQUANTEL

Authority required (STREAMLINED)

5659

Schistosomiasis

praziquantel 600 mg tablet, 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9447F (NP)	1	..	..	39.54	39.50	Biltricide [BN]

ANTINEMATODAL AGENTS

Benzimidazole derivatives

▪ ALBENDAZOLE

Authority required (STREAMLINED)

5607

Hydatid disease

Clinical criteria:

- The treatment must be in conjunction with surgery; OR
- The treatment must be used when a surgical cure cannot be achieved; OR
- The treatment must be used when surgery cannot be used.

albendazole 400 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8459F	1	2	..	165.53	39.50	Eskazole [AS]

▪ ALBENDAZOLE

Authority required (STREAMLINED)

5680

Tapeworm infestation

albendazole 200 mg tablet, 6

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8503M (NP)	1	1	..	33.13	34.34	Zentel [AS]

▪ ALBENDAZOLE

Authority required (STREAMLINED)

5817

Whipworm infestation

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

Authority required (STREAMLINED)

5712

Strongyloidiasis

Authority required (STREAMLINED)

5797

Hookworm infestation

albendazole 200 mg tablet, 6

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9047E NP	1	..	..	33.13	34.34	Zentel [AS]

Tetrahydropyrimidine derivatives

▪ PYRANTEL

pyrantel 125 mg tablet, 6

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3047J NP	1	..	..	17.84	19.05	Anthel 125 [AF]

pyrantel 250 mg tablet, 6

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3048K NP	1	..	..	24.61	25.82	Anthel 250 [AF]

Avermectines

▪ IVERMECTIN

Authority required (STREAMLINED)

4319

Onchocerciasis

ivermectin 3 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8359Y NP	1	..	..	31.65	32.86	Stromectol [MK]

▪ IVERMECTIN

Authority required (STREAMLINED)

4328

Strongyloidiasis

Authority required (STREAMLINED)

4565

Crusted (Norwegian) scabies

Clinical criteria:

- The condition must be established by clinical and/or parasitological examination, **AND**
- Patient must be undergoing topical therapy for this condition; OR
- Patient must have a contraindication to topical treatment.

Population criteria:

- Patient must weigh 15 kg or over, **AND**
- Patient must be 5 years of age or older.

Authority required (STREAMLINED)

4566

Human sarcoptic scabies

Clinical criteria:

- The condition must be established by clinical and/or parasitological examination, **AND**
- Patient must have completed and failed sequential treatment with topical permethrin and benzyl benzoate and finished the most recent course of topical therapy at least 4 weeks prior to initiating oral therapy; OR
- Patient must have a contraindication to topical treatment.

Population criteria:

- Patient must weigh 15 kg or over, **AND**
- Patient must be 5 years of age or older.

Note This drug is not PBS-subsidised for first line treatment of typical scabies.

ivermectin 3 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2868Y NP	2	2	..	*52.21	39.50	Stromectol [MK]

▪ ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS

ECTOPARASITICIDES, INCL. SCABICIDES

Pyrethrines, incl. synthetic compounds

▪ PERMETHRIN

permethrin 5% cream, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3054R NP	‡1	1	..	19.64	20.85	Lyclear [JT]

RESPIRATORY SYSTEM

NASAL PREPARATIONS

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE

Other nasal preparations

MUPIROCIN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6647

Staphylococcus aureus infection

Clinical criteria:

- Patient must have nasal colonisation with the bacteria.

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person.

mupirocin 2% (20 mg/g) ointment, 3 g

9440W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	..	..	24.61	25.82	Bactroban [GK]

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

ADRENERGICS, INHALANTS

Selective beta-2-adrenoreceptor agonists

FORMOTEROL (EFORMOTEROL)

Restricted benefit

Asthma

Clinical criteria:

- Patient must experience frequent episodes of the condition, **AND**
- Patient must be currently receiving treatment with oral corticosteroids; OR
- Patient must be currently receiving treatment with optimal doses of inhaled corticosteroids.

formoterol (eformoterol) fumarate dihydrate 12 microgram powder for inhalation, 60 capsules

8136F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	36.63	37.84	Foradile [SZ]

formoterol (eformoterol) fumarate dihydrate 12 microgram/actuation powder for inhalation, 60 actuations

8240Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	35.88	37.09	Oxis Turbuhaler [AP]

formoterol (eformoterol) fumarate dihydrate 6 microgram/actuation powder for inhalation, 60 actuations

8239P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	27.58	28.79	Oxis Turbuhaler [AP]

INDACATEROL

Note This drug is not PBS-subsidised for the treatment of asthma.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

indacaterol 150 microgram powder for inhalation, 30 capsules

5134F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.42	39.50	Onbrez [NV]

indacaterol 300 microgram powder for inhalation, 30 capsules

5137J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.42	39.50	Onbrez [NV]

SALBUTAMOL

salbutamol 100 microgram/actuation pressurised inhalation, 200 actuations

8288F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*18.51	19.72	[a] Asmol CFC-free [AL]
			[B]3.54	*22.05	19.72	[a] Ventolin CFC-free [GK]

salbutamol 200 microgram powder for inhalation, 128 capsules

10143W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	4	..	*21.83	23.04	Ventolin Rotacaps [GK]

▪ SALBUTAMOL

Restricted benefit

Bronchospasm

Clinical criteria:

- Patient must be unable to achieve co-ordinated use of other metered dose inhalers containing this drug.

salbutamol Oral pressurised inhalation in breath actuated device 100 micrograms (base) per dose (200 doses), CFC-free formulation, 1

8354Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*39.07	39.50	Airomir Autohaler [IA]

▪ SALBUTAMOL

Note Pharmaceutical benefits that have a 30 x 2 pack size and a 20 x 3 pack size are equivalent for the purposes of substitution.

Restricted benefit

Asthma

Clinical criteria:

- Patient must be unable to use this drug delivered from an oral pressurised inhalation device via a spacer.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must be unable to use this drug delivered from an oral pressurised inhalation device via a spacer.

salbutamol 2.5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules

2000G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*19.09	20.30	[a] APO-Salbutamol [TX] [a] Salbutamol Actavis [EA] [a] Salbutamol Sandoz [SZ]	[a] Butamol 2.5 [QA] [a] Salbutamol AN [ED]
			[B]0.50	*19.59	20.30	[a] Asmol 2.5 uni-dose [AF]	

salbutamol 5 mg/2.5 mL inhalation solution, 20 x 2.5 mL ampoules

11095Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	[B]1.98	*21.49	20.72	[a] Ventolin Nebules [GK]

salbutamol 5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules

2001H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*19.51	20.72	[a] APO-Salbutamol [TX] [a] Salbutamol Actavis [EA] [a] Salbutamol Sandoz [SZ]	[a] Butamol 5 [QA] [a] Salbutamol AN [ED]
			[B]0.50	*20.01	20.72	[a] Asmol 5 uni-dose [AF]	

salbutamol 2.5 mg/2.5 mL inhalation solution, 20 x 2.5 mL ampoules

11130T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	[B]2.01	*21.10	20.30	[a] Ventolin Nebules [GK]

▪ SALMETEROL

Restricted benefit

Asthma

Clinical criteria:

- Patient must experience frequent episodes of the condition, **AND**
- Patient must be currently receiving treatment with oral corticosteroids; OR
- Patient must be currently receiving treatment with optimal doses of inhaled corticosteroids.

salmeterol 50 microgram/actuation powder for inhalation, 60 actuations

8141L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	36.63	37.84	Serevent Accuhaler [GK]

▪ TERBUTALINE

terbutaline sulfate 500 microgram/actuation powder for inhalation, 100 actuations

2817G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*20.53	21.74	Bricanyl Turbuhaler [AP]

Adrenergics in combination with corticosteroids or other drugs, excl. anticholinergics

▪ BUDESONIDE + FORMOTEROL (EFORMOTEROL)

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids; OR
- Patient must have experienced frequent asthma symptoms while receiving treatment with oral or inhaled corticosteroids and require single maintenance and reliever therapy; OR
- Patient must have experienced frequent asthma symptoms while receiving treatment with a combination of an inhaled corticosteroid and long acting beta-2 agonist and require single maintenance and reliever therapy.

Population criteria:

- Patient must be aged 12 years or over.

budesonide 100 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 6 microgram/actuation powder for inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8796Y NP	‡1	5	..	54.64	39.50	Symbicort Turbuhaler 100/6 [AP]

budesonide 200 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 6 microgram/actuation powder for inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8625Y NP	‡1	5	..	58.68	39.50	Symbicort Turbuhaler 200/6 [AP]

▪ BUDESONIDE + FORMOTEROL (EFORMOTEROL)

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids; OR
- Patient must have experienced frequent asthma symptoms while receiving treatment with oral or inhaled corticosteroids and require single maintenance and reliever therapy; OR
- Patient must have experienced frequent asthma symptoms while receiving treatment with a combination of an inhaled corticosteroid and long acting beta-2 agonist.

Population criteria:

- Patient must be aged 12 years or over.

budesonide 100 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 3 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10015D NP	2	5	..	*56.29	39.50	Symbicort Rapihaler 100/3 [AP]

budesonide 50 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 3 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10024N NP	2	5	..	*52.47	39.50	Symbicort Rapihaler 50/3 [AP]

▪ BUDESONIDE + FORMOTEROL (EFORMOTEROL)

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 12 years or over.

Note Symbicort 400/12 is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**
- Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**
- The treatment must be for symptomatic treatment.

Note Patient must not be on a concomitant single agent long-acting beta-2 agonist.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

budesonide 400 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 12 microgram/actuation powder for inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8750M NP	‡1	5	..	86.19	39.50	Symbicort Turbuhaler 400/12 [AP]

▪ BUDESONIDE + FORMOTEROL (EFORMOTEROL)

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 12 years or over.

Note Unlike Symbicort Turbuhaler 200/6, Symbicort Rapihaler 200/6 is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy as the approved Product Information does not specify such use.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**
- Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**
- The treatment must be for symptomatic treatment.

Note Patient must not be on a concomitant single agent long-acting beta-2 agonist.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

budesonide 200 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 6 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10018G NP	2	5	..	*82.45	39.50	Symbicort Rapihaler 200/6 [AP]

▪ FLUTICASONE + FORMOTEROL (EFORMOTEROL)

Note Flutiform is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Note Flutiform is not indicated or PBS-subsidised for bronchodilator therapy in COPD.

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 12 years or over.

fluticasone propionate 250 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 10 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10008R NP	‡1	5	..	64.07	39.50	flutiform 250/10 [MF]

fluticasone propionate 50 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 5 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2827T NP	‡1	5	..	40.24	39.50	flutiform 50/5 [MF]

fluticasone propionate 125 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 5 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10007Q NP	‡1	5	..	48.10	39.50	flutiform 125/5 [MF]

▪ FLUTICASONE + SALMETEROL

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 4 years or older.

fluticasone propionate 100 microgram/actuation + salmeterol 50 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8430Q NP	‡1	5	..	41.56	39.50	Seretide Accuhaler 100/50 [GK]

fluticasone propionate 125 microgram/actuation + salmeterol 25 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8518H NP	‡1	5	..	48.25	39.50	[a] Fluticasone + Salmeterol Cipla 125/25 [LR] [a] Seretide MDI 125/25 [GK]	[a] SalplusF Inhaler 125/25 [YC]

fluticasone propionate 50 microgram/actuation + salmeterol 25 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8517G NP	‡1	5	..	41.56	39.50	Seretide MDI 50/25 [GK]

fluticasone propionate 250 microgram/actuation + salmeterol 50 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8431R NP	‡1	5	..	48.25	39.50	Seretide Accuhaler 250/50 [GK]

▪ FLUTICASONE + SALMETEROL

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 4 years or older.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**
- Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**
- The treatment must be for symptomatic treatment.

Note Patient must not be on a concomitant single agent long-acting beta-2 agonist.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8432T NP	‡1	5	..	61.39	39.50	Seretide Accuhaler 500/50 [GK]

fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8519J NP	‡1	5	..	61.39	39.50	[a] Fluticasone + Salmeterol Cipla 250/25 [LR] [a] Seretide MDI 250/25 [GK]	[a] SalplusF Inhaler 250/25 [YC]

▪ FLUTICASONE FUROATE + VILANTEROL

Note This drug is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Note This drug is not PBS-subsidised for the treatment of chronic obstructive pulmonary disease (COPD).

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 12 years or over.

fluticasone furoate 200 microgram/actuation + vilanterol 25 microgram/actuation powder for inhalation, 30 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11129R NP	‡1	5	..	71.62	39.50	Breo Ellipta 200/25 [GK]

▪ FLUTICASONE FUROATE + VILANTEROL

Restricted benefit

Asthma

Clinical criteria:

- Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

- Patient must be aged 12 years or over.

Note This drug is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**
- Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**
- The treatment must be for symptomatic treatment.

Note Patient must not be on a concomitant single agent long-acting beta-2 agonist.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

fluticasone furoate 100 microgram/actuation + vilanterol 25 microgram/actuation powder for inhalation, 30 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11124L NP	‡1	5	..	56.12	39.50	Breo Ellipta 100/25 [GK]

Adrenergics in combination with anticholinergics

▪ ACLIDINIUM + FORMOTEROL (EFORMOTEROL)

Note The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.

Note A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.

Note A LABA includes olodaterol, indacaterol, salmeterol, eformoterol or vilanterol.

Note This product is not PBS-subsidised for the treatment of asthma.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

Authority required (STREAMLINED)

5763

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

aclidinium 340 microgram/actuation + formoterol (eformoterol) fumarate dihydrate 12 microgram/actuation inhalation: powder for, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10565C NP	‡1	5	..	91.18	39.50	Brimica Genuair [FK]

▪ INDACATEROL + GLYCOPYRRONIUM

Note The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.

Note A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.

Note A LABA includes olodaterol, indacaterol, salmeterol, eformoterol or vilanterol.

Note This product is not PBS-subsidised for the treatment of asthma.

Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

Authority required (STREAMLINED)

5763

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

indacaterol 110 microgram + glycopyrronium 50 microgram powder for inhalation, 30 capsules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10156M NP	1	5	..	90.53	39.50	ultibro breezhaler 110/50 [NV]

▪ TIOTROPIUM + OLODATEROL

Note The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.
Note A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.
Note A LABA includes olodaterol, indacaterol, salmeterol, eformoterol or vilanterol.
Note This product is not PBS-subsidised for the treatment of asthma.
Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

Authority required (STREAMLINED)
5763
Chronic obstructive pulmonary disease (COPD)
Clinical criteria:

- Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

tiotropium 2.5 microgram/actuation + olodaterol 2.5 microgram/actuation inhalation solution, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10557P NP	‡1	5	..	90.01	39.50	Spiolto Respimat [BY]

▪ UMECLIDINIUM + VILANTEROL

Note The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.
Note A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.
Note A LABA includes olodaterol, indacaterol, salmeterol, eformoterol or vilanterol.
Note This product is not PBS-subsidised for the treatment of asthma.
Note This product is not indicated for the initiation of bronchodilator therapy in COPD.

Authority required (STREAMLINED)
5763
Chronic obstructive pulmonary disease (COPD)
Clinical criteria:

- Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

umeclidinium 62.5 microgram/actuation + vilanterol 25 microgram/actuation powder for inhalation, 30 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10188F NP	‡1	5	..	92.56	39.50	Anoro Ellipta 62.5/25 [GK]

OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS

Glucocorticoids

▪ BECLOMETASONE

beclometasone dipropionate 50 microgram/actuation pressurised inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8406K NP	‡1	5	..	21.72	22.93	Qvar 50 [IA]

beclometasone dipropionate 100 microgram/actuation pressurised inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8407L NP	‡1	5	..	33.43	34.64	Qvar 100 [IA]

▪ BECLOMETASONE

Restricted benefit
Asthma
Clinical criteria:

- Patient must be unable to achieve co-ordinated use of other metered dose inhalers containing this drug.

beclometasone dipropionate 100 microgram/actuation breath activated inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8409N NP	‡1	5	..	38.11	39.32	Qvar 100 Autohaler [IA]

beclometasone dipropionate 50 microgram/actuation breath activated inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8408M NP	‡1	5	..	28.81	30.02	Qvar 50 Autohaler [IA]

▪ BUDESONIDE

budesonide 100 microgram/actuation powder for inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2070Y NP	‡1	5	..	25.07	26.28	Pulmicort Turbuhaler [AP]

budesonide 400 microgram/actuation powder for inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2072C NP	‡1	5	..	44.27	39.50	Pulmicort Turbuhaler [AP]

budesonide 200 microgram/actuation powder for inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2071B NP	‡1	5	..	31.45	32.66	Pulmicort Turbuhaler [AP]

▪ BUDESONIDE

Authority required (STREAMLINED)

6340

Severe chronic asthma

Clinical criteria:

- Patient must require long-term steroid therapy, **AND**
- Patient must not be able to use other forms of inhaled steroid therapy.

budesonide 500 microgram/2 mL inhalation solution, 30 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2065Q NP	‡1	5	..	37.07	38.28	Pulmicort Respules [AP]

budesonide 1 mg/2 mL inhalation solution, 30 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2066R NP	‡1	5	..	47.27	39.50	Pulmicort Respules [AP]

▪ CICLESONIDE

ciclesonide 80 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8853Y NP	‡1	5	..	27.39	28.60	Alvesco 80 [AP]

ciclesonide 160 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8854B NP	‡1	5	..	40.85	39.50	Alvesco 160 [AP]

▪ FLUTICASONE

fluticasone propionate 100 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8147T NP	‡1	5	..	18.50	19.71	Flixotide Junior Accuhaler [GK]

fluticasone propionate 250 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8148W NP	‡1	5	..	27.92	29.13	Flixotide Accuhaler [GK]

fluticasone propionate 50 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8516F NP	‡1	5	..	18.50	19.71	Flixotide Junior [GK]

fluticasone propionate 500 microgram/actuation powder for inhalation, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8149X NP	‡1	1	..	42.06	39.50	Flixotide Accuhaler [GK]

fluticasone propionate 250 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8346G NP	‡1	1	..	42.06	39.50	[a] Flixotide [GK]	[a] Fluticasone Cipla Inhaler [LR]

fluticasone propionate 125 microgram/actuation pressurised inhalation, 120 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8345F NP	‡1	5	..	27.92	29.13	[a] Flixotide [GK]	[a] Fluticasone Cipla Inhaler [LR]

Anticholinergics

▪ ACLIDINIUM

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

aclidinium 322 microgram/actuation inhalation: powder for, 60 actuations

10124W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	61.97	39.50	Bretaris Genuair [FK]

▪ GLYCOPYRRONIUM

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

glycopyrronium 50 microgram powder for inhalation, 30 capsules

10059K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	61.97	39.50	seebri breezhaler [NV]

▪ IPRATROPIUM

ipratropium bromide 20 microgram/actuation inhalation: pressurised, 200 actuations

8671J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*34.93	36.14	Atrovent [BY]

▪ IPRATROPIUM

Restricted benefit

Asthma

Clinical criteria:

- Patient must be unable to use this drug delivered from an oral pressurised inhalation device via a spacer.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

- Patient must be unable to use this drug delivered from an oral pressurised inhalation device via a spacer.

ipratropium bromide 250 microgram/mL inhalation solution, 30 x 1 mL ampoules

1542E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*27.33	28.54	[a] Aeron 250 [QA] [a] Ipratrin [AF]	[a] APO-Ipratropium [TX]
			[B]0.50	*27.83	28.54	[a] Atrovent [BY]	

ipratropium bromide 500 microgram/mL inhalation solution, 30 x 1 mL ampoules

8238N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*30.27	31.48	[a] Aeron 500 [QA] [a] Ipratrin Adult [AF]	[a] APO-Ipratropium [TX]
			[B]0.50	*30.77	31.48	[a] Atrovent Adult [BY]	

▪ TIOTROPIUM

Restricted benefit

Bronchospasm and dyspnoea associated with chronic obstructive pulmonary disease

Treatment Phase: Long-term maintenance treatment

tiotropium 2.5 microgram/actuation inhalation solution, 60 actuations

10509D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	59.42	39.50	Spiriva Respimat [BY]

▪ TIOTROPIUM

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

tiotropium 18 microgram powder for inhalation, 30 capsules

8626B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	59.42	39.50	Spiriva [BY]

▪ TIOTROPIUM

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Restricted benefit

Severe asthma

Clinical criteria:

- Patient must have experienced at least one severe exacerbation, which has required documented use of systemic corticosteroids, in the previous 12 months while receiving optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- The treatment must be used in combination with a maintenance combination of an inhaled corticosteroid and a long acting beta-2 agonist.

Optimised asthma therapy includes adherence to the maintenance combination of an inhaled corticosteroid (at least 800 micrograms budesonide per day or equivalent) and a long acting beta-2 agonist.

tiotropium 2.5 microgram/actuation inhalation solution, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11043F NP	‡1	5	..	59.42	39.50	Spiriva Respimat [BY]

▪ UMECLIDINIUM

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

umeclidinium 62.5 microgram/actuation inhalation: powder for, 30 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10187E NP	‡1	5	..	61.97	39.50	Incruse Ellipta [GK]

Antiallergic agents, excl. corticosteroids

▪ CROMOGLYCATE

sodium cromoglycate 5 mg/actuation pressurised inhalation, 112 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8334P NP	‡1	5	..	38.82	39.50	Intal Forte CFC-Free [SW]

sodium cromoglycate 1 mg/actuation pressurised inhalation, 200 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8767K NP	‡1	5	..	34.64	35.85	Intal CFC-Free [SW]

▪ NEDOCROMIL

nedocromil sodium 2 mg/actuation pressurised inhalation, 112 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8365G NP	‡1	5	..	38.72	39.50	Tilade CFC-Free [SW]

ADRENERGICS FOR SYSTEMIC USE

Alpha- and beta-adrenoreceptor agonists

▪ ADRENALINE

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1016L NP	1	1	..	22.58	23.79	Link Medical Products Pty Ltd [LM]

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5004J DP	1	..	..	22.58	23.79	Link Medical Products Pty Ltd [LM]

▪ ADRENALINE

Note The auto-injector should be provided in the framework of a comprehensive anaphylaxis prevention program and an emergency action plan including training in recognition of the symptoms of anaphylaxis and the use of the auto-injector device. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au.)

Note Authority approvals will be limited to a maximum quantity of 2 auto-injectors at any one time.

Note No applications for repeats will be authorised.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a clinical immunologist; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with an allergist; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a paediatrician; OR
- Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a respiratory physician.

The name of the specialist consulted must be provided at the time of application for initial supply.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

- Patient must have been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Continuing sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug.

adrenaline 300 microgram/0.3 mL injection, 1 dose

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8698T NP	1	..	..	97.10	39.50	EpiPen [AL]

adrenaline 150 microgram/0.3 mL injection, 1 dose

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8697R NP	1	..	..	97.10	39.50	EpiPen Jr. [AL]

Selective beta-2-adrenoreceptor agonists

▪ SALBUTAMOL

salbutamol 2 mg/5 mL oral liquid, 150 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1103C NP	2	5	..	*24.81	26.02	Ventolin [GK]

▪ TERBUTALINE

terbutaline sulfate 500 microgram/mL injection, 5 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1034K NP	1	..	..	31.06	32.27	Bricanyl [AP]

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Xanthines

▪ THEOPHYLLINE

Caution Because of variable effects of food on absorption of sustained release theophylline preparations, patients stabilised on one brand should not be changed to another without appropriate monitoring.

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

theophylline 300 mg modified release tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8231F NP	1	5	..	17.94	19.15	Nuelin-SR 300 [IA]

theophylline 200 mg modified release tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8230E NP	1	5	..	15.83	17.04	Nuelin-SR 200 [IA]

theophylline 250 mg modified release tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2634P NP	1	5	..	16.79	18.00	Nuelin-SR 250 [IA]

theophylline 133.3 mg/25 mL oral liquid, 500 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2614N NP	‡1	5	..	16.68	17.89	Nuelin [IA]

Leukotriene receptor antagonists

▪ MONTELUKAST

Note This drug is not PBS-subsidised for use in a child aged 2 to 5 years with moderate to severe asthma. It is not intended as an alternative for a child aged 2 to 5 years who requires a corticosteroid as a preventer medication.

Note This drug is not subsidised in a child aged 2 to 5 years for use in combination with other preventer medications. PBS subsidy for this drug will therefore cease for a child aged 2 to 5 years who requires a preventer medication in addition to this drug.

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6666

Asthma

Treatment Phase: First-line prevention

Population criteria:

- Patient must be aged 2 to 5 years inclusive.

Clinical criteria:

- The condition must be frequent intermittent; OR
- The condition must be mild persistent, **AND**
- The treatment must be the single preventer agent, **AND**
- The treatment must be an alternative to sodium cromoglycate; OR
- The treatment must be an alternative to nedocromil sodium.

montelukast 4 mg chewable tablet, 28

8627C (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	18.24	19.45	[a] APO-Montelukast [TX] [a] Chem mart Montelukast [CH] [a] Montelukast AN [EA] [a] Montelukast Sandoz 4 [SZ] [a] Terry White Chemists Montelukast [TW]	[a] Auro-Montelukast Tabs 4 [DO] [a] Lukair [AL] [a] Montelukast GH [GQ] [a] Respikast 4 [RW]
		[B]3.00	21.24	19.45	[a] Singulair [MK]	

▪ MONTELUKAST

Note This drug is not PBS-subsidised for use in a patient aged 15 years or older, or for use in addition to a long-acting beta-agonist in any age group, or for use as a single second line preventer, as an alternative to corticosteroids, in a child aged 6 to 14 years with moderate to severe asthma.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6674

Asthma

Treatment Phase: First-line prevention

Clinical criteria:

- The condition must be frequent intermittent; OR
- The condition must be mild persistent, **AND**
- The treatment must be the single preventer agent, **AND**
- The treatment must be an alternative to sodium cromoglycate; OR
- The treatment must be an alternative to nedocromil sodium.

Population criteria:

- Patient must be aged 6 to 14 years inclusive.

Authority required (STREAMLINED)

6684

Asthma

Treatment Phase: Prevention of condition

Clinical criteria:

- The condition must be exercise-induced, **AND**
- The treatment must be as an alternative to adding salmeterol xinafoate; OR
- The treatment must be as an alternative to adding eformoterol fumarate, **AND**
- The condition must be otherwise well controlled while receiving optimal dose inhaled corticosteroid, **AND**
- Patient must require short-acting beta-2 agonist 3 or more times per week for prevention or relief of residual exercise-related symptoms.

Population criteria:

- Patient must be aged 6 to 14 years inclusive.

montelukast 5 mg chewable tablet, 28

8628D (NP)

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	17.82	19.03	[a] APO-Montelukast [TX] [a] Chem mart Montelukast [CH] [a] Montelukast AN [EA] [a] Montelukast Sandoz 5 [SZ] [a] Terry White Chemists Montelukast [TW]	[a] Auro-Montelukast Tabs 5 [DO] [a] Lukair [AL] [a] Montelukast GH [GQ] [a] Respikast 5 [RW]
		[B]3.00	20.82	19.03	[a] Singulair [MK]	

COUGH AND COLD PREPARATIONS

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS

Opium alkaloids and derivatives

CODEINE

codeine phosphate hemihydrate 30 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1214X NP	1	..	..	20.50	21.71	Fawns and McAllan Proprietary Limited [FM]

ANTIHISTAMINES FOR SYSTEMIC USE

ANTIHISTAMINES FOR SYSTEMIC USE

Phenothiazine derivatives

PROMETHAZINE

promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1948M NP	2	..	..	*38.67	39.50	Hospira Pty Limited [PF]

SENSORY ORGANS

OPHTHALMOLOGICALS

ANTIINFECTIVES

Antibiotics

AZITHROMYCIN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Trachoma

azithromycin 500 mg tablet, 2

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8336R NP	1	2	..	15.37	16.58	[a] APO-Azithromycin [TX] [a] Azithromycin Sandoz [SZ] [a] Terry White Chemists Azithromycin [TW]	[a] Azithromycin Mylan [AF] [a] Chem mart Azithromycin [CH] [a] Zithromax [PF]

azithromycin 200 mg/5 mL powder for oral liquid, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8201P NP	‡1	..	..	#26.26	27.83	Zithromax [PF]

CHLORAMPHENICOL

Restricted benefit
For treatment of a patient identifying as Aboriginal or Torres Strait Islander

chloramphenicol 0.5% eye drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11112W OP NP MW	‡1	2	..	15.07	16.28	Chlorsig [QA]

GENTAMICIN

Restricted benefit
Perioperative use in ophthalmic surgery
Restricted benefit
Suspected Pseudomonal eye infection

gentamicin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5566Y OP	‡1	2	..	21.41	22.62	Genoptic [AG]

GENTAMICIN

Restricted benefit
Invasive ocular infection
Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected Pseudomonal eye infection

gentamicin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1441W	‡1	2	..	21.41	22.62	Genoptic [AG]

▪ TOBRAMYCIN

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected Pseudomonal eye infection

tobramycin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5569D OP	‡1	2	..	21.71	22.92	Tobrex [NV]

tobramycin 0.3% eye ointment, 3.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5570E OP	‡1	..	..	24.27	25.48	Tobrex [NV]

▪ TOBRAMYCIN

Restricted benefit

Invasive ocular infection

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected Pseudomonal eye infection

tobramycin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2328M	‡1	2	..	21.71	22.92	Tobrex [NV]

tobramycin 0.3% eye ointment, 3.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2329N	‡1	..	..	24.27	25.48	Tobrex [NV]

Antivirals

▪ ACICLOVIR

Restricted benefit

Herpes simplex keratitis

aciclovir 3% eye ointment, 4.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5501M OP	‡1	..	..	38.08	39.29	Zovirax [GK]

▪ ACICLOVIR

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Herpes simplex keratitis

aciclovir 3% eye ointment, 4.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1002R NP	‡1	..	..	38.08	39.29	Zovirax [GK]

Fluoroquinolones

▪ CIPROFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

- Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ciprofloxacin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1217C	2	..	..	*30.27	31.48	[a] CiloQuin [NM]
			[B]4.36	*34.63	31.48	[a] Ciloxan [NV]

▪ CIPROFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

- Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ciprofloxacin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5564W OP	2	..	..	*30.27	31.48	[a] CiloQuin [NM]
			[B]4.36	*34.63	31.48	[a] Ciloxan [NV]

▪ OFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

- Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ofloxacin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5567B OP	2	..	..	*34.95	36.16	Ocuflox [AG]

▪ OFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

- Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ofloxacin 0.3% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8383F	2	..	..	*34.95	36.16	Ocuflox [AG]

ANTIINFLAMMATORY AGENTS

Corticosteroids, plain

▪ DEXAMETHASONE

DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1288T NP	‡1	2	..	14.73	15.94	Maxidex [NV]

▪ DEXAMETHASONE

Note No applications for increased maximum quantities will be authorised.

Note No applications for increased repeats will be authorised.

DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5565X OP	‡1	..	..	14.73	15.94	Maxidex [NV]

▪ DEXAMETHASONE

Note Special Pricing Arrangements apply.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by an ophthalmologist.

Clinical criteria:

- Patient must have visual impairment due to diabetic macular oedema, **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 78 and 39 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/32 to 20/160), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**

- Patient must have a contraindication to vascular endothelial growth factor (VEGF) inhibitors; OR
- Patient must be unsuitable for treatment with VEGF inhibitors; OR
- Patient must have failed prior treatment with VEGF inhibitors, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Population criteria:

- Patient must have had a cataract removed in the treated eye; OR
- Patient must be scheduled for cataract surgery in the treated eye.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by an ophthalmologist.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Population criteria:

- Patient must have had a cataract removed in the treated eye; OR
- Patient must be scheduled for cataract surgery in the treated eye.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Grandfathering treatment

Treatment criteria:

- Must be treated by an ophthalmologist.

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 November 2016, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Population criteria:

- Patient must have had a cataract removed in the treated eye; OR
- Patient must be scheduled for cataract surgery in the treated eye.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

dexamethasone 700 microgram implant, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10943Y	1	1	..	1354.79	39.50	Ozurdex [AG]

▪ FLUOROMETHOLONE

fluorometholone 0.1% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1204J NP	‡1	5	..	14.55	15.76	Flucon [NV]	FML Liquifilm [AG]

▪ FLUOROMETHOLONE

Note No applications for increased maximum quantities will be authorised.
Note No applications for increased repeats will be authorised.

fluorometholone 0.1% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5513E OP	‡1	..	..	14.55	15.76	Flucon [NV]	FML Liquifilm [AG]

▪ FLUOROMETHOLONE ACETATE

fluorometholone acetate 0.1% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1438Q NP	‡1	2	..	14.55	15.76	Flarex [NV]

▪ FLUOROMETHOLONE ACETATE

Note No applications for increased maximum quantities will be authorised.
Note No applications for increased repeats will be authorised.

fluorometholone acetate 0.1% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5533F OP	‡1	..	..	14.55	15.76	Flarex [NV]

▪ HYDROCORTISONE ACETATE

hydrocortisone acetate 1% eye ointment, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2441L NP	‡1	..	..	16.54	17.75	Hycor [QA]

▪ HYDROCORTISONE ACETATE

Note No applications for increased maximum quantities will be authorised.
Note No applications for increased repeats will be authorised.

hydrocortisone acetate 1% eye ointment, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5516H OP	‡1	..	..	16.54	17.75	Hycor [QA]

Corticosteroids and mydriatics in combination

▪ PREDNISOLONE ACETATE + PHENYLEPHRINE

Restricted benefit
Corneal grafts
Restricted benefit
Uveitis

prednisolone acetate 1% + phenylephrine hydrochloride 0.12% eye drops, 10 mL

3112T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	27.96	29.17	Prednefrin Forte [AG]

▪ PREDNISOLONE ACETATE + PHENYLEPHRINE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Uveitis

prednisolone acetate 1% + phenylephrine hydrochloride 0.12% eye drops, 10 mL

5568C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	..	..	27.96	29.17	Prednefrin Forte [AG]

ANTIGLAUCOMA PREPARATIONS AND MIOTICS

Sympathomimetics in glaucoma therapy1)

▪ APRACLONIDINE

Restricted benefit
Intra-ocular pressure
Clinical criteria:
- The treatment must be for short-term reduction of intra-ocular pressure, **AND**
- Patient must already be on maximally tolerated anti-glaucoma therapy.

apraclonidine 0.5% eye drops, 10 mL

8083K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	40.40	39.50	Iopidine 0.5% [NV]

▪ BRIMONIDINE

brimonidine tartrate 0.2% eye drops, 5 mL

8351M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	23.02	24.23	[a] Enidin [PE]
			[B]1.42	24.44	24.23	[a] Alphagan [AG]

brimonidine tartrate 0.15% eye drops, 5 mL

5298W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	23.02	24.23	Alphagan P 1.5 [AG]

▪ BRIMONIDINE

Note For prescribing in accordance with Optometry Board of Australia guidelines.

brimonidine tartrate 0.2% eye drops, 5 mL

5534G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	23.02	24.23	[a] Enidin [PE]
			[B]1.42	24.44	24.23	[a] Alphagan [AG]

brimonidine tartrate 0.15% eye drops, 5 mL

5563T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	23.02	24.23	Alphagan P 1.5 [AG]

▪ BRIMONIDINE + TIMOLOL

Restricted benefit
Elevated intra-ocular pressure
Clinical criteria:
- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL

8826M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	28.14	29.35	Combigan [AG]

▪ BRIMONIDINE + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL

5535H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	28.14	29.35	Combigan [AG]

Parasympathomimetics

▪ PILOCARPINE

pilocarpine hydrochloride 4% eye drops, 15 mL

2598R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	19.97	21.18	Isopto Carpine [NV]

pilocarpine hydrochloride 2% eye drops, 15 mL

2596P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	17.49	18.70	Isopto Carpine [NV]

pilocarpine hydrochloride 1% eye drops, 15 mL

2595N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	16.40	17.61	Isopto Carpine [NV]

▪ PILOCARPINE

Note For prescribing in accordance with Optometry Board of Australia guidelines.

pilocarpine hydrochloride 4% eye drops, 15 mL

5538L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	19.97	21.18	Isopto Carpine [NV]

pilocarpine hydrochloride 2% eye drops, 15 mL

5537K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	17.49	18.70	Isopto Carpine [NV]

pilocarpine hydrochloride 1% eye drops, 15 mL

5536J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	16.40	17.61	Isopto Carpine [NV]

Carbonic anhydrase inhibitors

▪ ACETAZOLAMIDE

Note Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

acetazolamide 250 mg tablet, 100

1004W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	26.91	28.12	Diamox [RW]

▪ BRINZOLAMIDE

brinzolamide 1% eye drops, 5 mL

8483L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	25.31	26.52	[a] BrinzoQuin [NM]
			[B]4.78	30.09	26.52	[a] Azopt [NV]

▪ BRINZOLAMIDE

Note For prescribing in accordance with Optometry Board of Australia guidelines.

brinzolamide 1% eye drops, 5 mL

5540N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	25.31	26.52	[a] BrinzoQuin [NM]
			[B]4.78	30.09	26.52	[a] Azopt [NV]

▪ BRINZOLAMIDE + BRIMONIDINE

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brinzolamide 1% + brimonidine tartrate 0.2% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10536M	‡1	5	..	27.65	28.86	Simbrinza 1%/0.2% [NV]

▪ BRINZOLAMIDE + BRIMONIDINE

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brinzolamide 1% + brimonidine tartrate 0.2% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10547D OP	‡1	5	..	27.65	28.86	Simbrinza 1%/0.2% [NV]

▪ BRINZOLAMIDE + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brinzolamide 1% + timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3438Y	‡1	5	..	28.88	30.09	Azarga [NV]

▪ BRINZOLAMIDE + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

brinzolamide 1% + timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5562R OP	‡1	5	..	28.88	30.09	Azarga [NV]

▪ DORZOLAMIDE

dorzolamide 2% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8488R	‡1	5	..	21.96	23.17	[a] APO-Dorzolamide [TX] [a] Trusopt [MF]	[a] Trusamide [QA]

▪ DORZOLAMIDE

Note For prescribing in accordance with Optometry Board of Australia guidelines.

dorzolamide 2% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5541P OP	‡1	5	..	21.96	23.17	[a] APO-Dorzolamide [TX] [a] Trusopt [MF]	[a] Trusamide [QA]

▪ DORZOLAMIDE + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

dorzolamide 2% + timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8567X	‡1	5	..	24.08	25.29	[a] APO-Dorzolamide/Timolol 20/5 [TX]	[a] Cosdor [QA]
						[a] DORZOLAMIDE/TIMOLOL AN 20/5 [EA]	[a] Dorzolamide/Timolol Sandoz 20/5 [SZ]
			[B]1.00	25.08	25.29	[a] Cosopt [MF]	

▪ DORZOLAMIDE + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

dorzolamide 2% + timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5542Q OP	‡1	5	..	24.08	25.29	[a] APO-Dorzolamide/Timolol 20/5 [TX]	[a] Cosdor [QA]
						[a] DORZOLAMIDE/TIMOLOL AN 20/5 [EA]	[a] Dorzolamide/Timolol Sandoz 20/5 [SZ]
			[B]1.00	25.08	25.29	[a] Cosopt [MF]	

Beta blocking agents1)

▪ BETAXOLOL

betaxolol 0.25% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2811Y	‡1	5	..	18.35	19.56	Betoptic S [NV]

betaxolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2825Q	‡1	5	..	18.35	19.56	[a] BetoQuin [NM]
			[B]4.76	23.11	19.56	[a] Betoptic [NV]

▪ BETAXOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

betaxolol 0.25% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5543R OP	‡1	5	..	18.35	19.56	Betoptic S [NV]

betaxolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5544T OP	‡1	5	..	18.35	19.56	[a] BetoQuin [NM]
			[B]4.76	23.11	19.56	[a] Betoptic [NV]

▪ TIMOLOL

timolol 0.5% eye drops, 2.5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1926J	‡1	5	..	16.87	18.08	Timoptol XE [MF]

timolol 0.1% eye gel, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8803H	‡1	5	..	19.34	20.55	Nyogel [AS]

timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1279H	‡1	5	..	16.81	18.02	Timoptol [MF]

timolol 0.25% eye drops, 2.5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1925H	‡1	5	..	16.69	17.90	Timoptol XE [MF]

▪ TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

timolol 0.5% eye drops, 2.5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5550D OP	‡1	5	..	16.87	18.08	Timoptol XE [MF]

timolol 0.1% eye gel, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5546X OP	‡1	5	..	19.34	20.55	Nyogel [AS]

timolol 0.5% eye drops, 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5548B OP	‡1	5	..	16.81	18.02	Timoptol [MF]

timolol 0.25% eye drops, 2.5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5549C OP	‡1	5	..	16.69	17.90	Timoptol XE [MF]

Prostaglandin analogues1)

▪ BIMATOPROST

bimatoprost 0.03% eye drops, 3 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8620Q	‡1	5	..	36.01	37.22	[a] Bimatoprost Sandoz [SZ] [a] Lumigan [AG]	[a] Bimtop [QA]

bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10046R	‡1	5	..	32.01	33.22	Lumigan PF [AG]

▪ BIMATOPROST

Note For prescribing in accordance with Optometry Board of Australia guidelines.

bimatoprost 0.03% eye drops, 3 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5551E OP	‡1	5	..	36.01	37.22	[a] Bimatoprost Sandoz [SZ] [a] Lumigan [AG]	[a] Bimtop [QA]

bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10053D OP	‡1	5	..	32.01	33.22	Lumigan PF [AG]

▪ BIMATOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10107Y	‡1	5	..	35.74	36.95	GANfort PF 0.3/5 [AG]

▪ BIMATOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL

9464D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	40.46	39.50	Ganfort 0.3/5 [AG]

▪ BIMATOPROST + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses

10108B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	35.74	36.95	GANfort PF 0.3/5 [AG]

bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL

5558M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	40.46	39.50	Ganfort 0.3/5 [AG]

▪ LATANOPROST

latanoprost 0.005% eye drops, 2.5 mL

8243W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	5	..	16.92	18.13	[a] APO-Latanoprost [TX] [a] Lanpro [JU] [a] Latanoprost GH [GQ] [a] Terry White Chemists Latanoprost [TW] [a] Xalatan [PF]	[a] Chem mart Latanoprost [CH] [a] Latanoprost Actavis [EA] [a] Latanoprost Sandoz [SZ] [a] Xalaprost [QA]

▪ LATANOPROST

Note For prescribing in accordance with Optometry Board of Australia guidelines.

latanoprost 0.005% eye drops, 2.5 mL

5552F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	‡1	5	..	16.92	18.13	[a] APO-Latanoprost [TX] [a] Lanpro [JU] [a] Latanoprost GH [GQ] [a] Terry White Chemists Latanoprost [TW] [a] Xalatan [PF]	[a] Chem mart Latanoprost [CH] [a] Latanoprost Actavis [EA] [a] Latanoprost Sandoz [SZ] [a] Xalaprost [QA]

▪ LATANOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL

8895E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	5	..	21.37	22.58	[a] APO-Latanoprost/Timolol 0.05/5 [TX] [a] Latanoprost/timolol AN 50/5 [EA] [a] Xalacom [PF]	[a] Lantim [JU] [a] Latanoprost/Timolol Sandoz 50/5 [SZ] [a] Xalamol 50/5 [QA]

▪ LATANOPROST + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR

- Patient must have ocular hypertension.

latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL

5553G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	‡1	5	..	21.37	22.58	[a] APO-Latanoprost/Timolol 0.05/5 [TX] [a] Latanoprost/timolol AN 50/5 [EA] [a] Xalacom [PF]	[a] Lantim [JU] [a] Latanoprost/Timolol Sandoz 50/5 [SZ] [a] Xalamol 50/5 [QA]

▪ TAFLUPROST

tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses

2755B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	34.92	36.13	Saflutan [MF]

▪ TAFLUPROST

Note For prescribing in accordance with Optometry Board of Australia guidelines.

tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses

2748P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	34.92	36.13	Saflutan [MF]

▪ TRAVOPROST

travoprost 0.004% eye drops, 2.5 mL

8597L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	40.75	39.50	Travatan [NV]

▪ TRAVOPROST

Note For prescribing in accordance with Optometry Board of Australia guidelines.

travoprost 0.004% eye drops, 2.5 mL

5554H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	40.75	39.50	Travatan [NV]

▪ TRAVOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

travoprost 0.004% + timolol 0.5% eye drops, 2.5 mL

9057Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	45.21	39.50	Duotrav [NV]

▪ TRAVOPROST + TIMOLOL

Note For prescribing in accordance with Optometry Board of Australia guidelines.

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

- The condition must have been inadequately controlled with monotherapy, **AND**
- Patient must have open-angle glaucoma; OR
- Patient must have ocular hypertension.

travoprost 0.004% + timolol 0.5% eye drops, 2.5 mL

5555J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	45.21	39.50	Duotrav [NV]

MYDRIATICS AND CYCLOPLEGICS

Anticholinergics

▪ ATROPINE SULFATE MONOHYDRATE

atropine sulfate monohydrate 1% eye drops, 15 mL

1093M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	23.78	24.99	Atropt [QA]

OCULAR VASCULAR DISORDER AGENTS

Antineovascularisation agents

▪ AFLIBERCEPT

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to diabetic macular oedema, **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 78 and 39 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/32 to 20/160), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

aflibercept 4 mg/0.1 mL injection, 0.1 mL vial

10505X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1149.44	39.50	Eylea [BN]

▪ AFLIBERCEPT

Note Special Pricing Arrangements apply.

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority approvals will be administered by the Complex Drugs Unit of the Department of Human Services.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum number of repeats may be authorised.

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to branched retinal vein occlusion (BRVO), **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 20 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/400), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO), **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 24 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/320), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

aflibercept 4 mg/0.1 mL injection, 0.1 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2168D	1	2	..	1149.44	39.50	Eylea [BN]

▪ RANIBIZUMAB

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Note Pharmaceutical benefits that have the form ranibizumab 0.165 mL injection syringe and pharmaceutical benefits that have the form ranibizumab 0.23 mL injection vial are equivalent for the purposes of substitution.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to diabetic macular oedema, **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 78 and 39 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/32 to 20/160), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Diabetic Macular Oedema (DMO) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Authority required

Diabetic macular oedema (DMO)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with laser photocoagulation, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

ranibizumab 2.3 mg/0.23 mL injection, 0.23 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10373Y	1	5	..	1149.44	39.50	[a] Lucentis [NV]

ranibizumab 1.65 mg/0.165 mL injection, 1 x 0.165 mL syringe

10374B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	1149.44	39.50	[a] Lucentis [NV]

▪ RANIBIZUMAB

Note Special Pricing Arrangements apply.

Note Pharmaceutical benefits that have the form ranibizumab 0.165 mL injection syringe and pharmaceutical benefits that have the form ranibizumab 0.23 mL injection vial are equivalent for the purposes of substitution.

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to branched retinal vein occlusion (BRVO), **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 20 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/400), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO), **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 24 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/320), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

ranibizumab 1.65 mg/0.165 mL injection, 1 x 0.165 mL syringe

10138N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1149.44	39.50	[a] Lucentis [NV]

▪ RANIBIZUMAB

Note Special Pricing Arrangements apply.

Note Pharmaceutical benefits that have the form ranibizumab 0.165 mL injection syringe and pharmaceutical benefits that have the form ranibizumab 0.23 mL injection vial are equivalent for the purposes of substitution.

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be due to age-related macular degeneration (AMD), **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to branched retinal vein occlusion (BRVO), **AND**

- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 20 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/400), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Branch retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO), **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score between 73 and 24 letters based on the early treatment diabetic retinopathy study chart administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/320), in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography; OR
- The condition must be diagnosed by fluorescein angiography, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form; and

c) a copy of the optical coherence tomography or fluorescein angiogram report.

A telephone application must be made following submission by facsimile of a copy of a completed Retinal Vein Occlusion Initial PBS authority application Supporting information form and a copy of the optical coherence tomography or fluorescein angiogram report.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Central retinal vein occlusion with macular oedema

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for the same eye, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

ranibizumab 2.3 mg/0.23 mL injection, 0.23 mL vial

1382R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	1149.44	39.50	[a] Lucentis [NV]

▪ VERTEPORFIN

Note The Department of Human Services should be notified if treatment is abandoned prior to completion of the laser activation step but after infusion of verteporfin. Telephone 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The reason treatment is abandoned must be provided. Where such notification has been made, the treatment so affected will not count towards the maximum.

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be predominantly classic (greater than or equal to 50%).

Treatment criteria:

- Must be treated by an ophthalmologist.

Clinical criteria:

- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The condition must be due to age-related macular degeneration (AMD), **AND**
- The condition must be diagnosed by fluorescein angiography, **AND**
- Patient must have a baseline visual acuity equal to or better than 6/60 (20/200).

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and

c) a copy of the fluorescein angiogram demonstrating that the CNV is predominantly classic (greater than or equal to 50%).

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the fluorescein angiogram.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note No more than 15 treatments (1 initial and 14 continuing) per eye will be authorised.

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial PBS-subsidised treatment

Clinical criteria:

- The condition must be predominantly classic (greater than or equal to 50%), **AND**
- The condition must be due to macular degeneration, **AND**

- Patient must have been authorised by the Angiogram Review Panel to receive treatment with verteporfin in the same eye under the MBS Visudyne Therapy Program, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated by a ophthalmologist.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

(a) a completed authority prescription form; and

(b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form, which includes the date of review by the Angiogram Review Panel and the number of treatments administered in that eye under the MBS Visudyne Therapy Program; and

(c) a copy of the fluorescein angiogram demonstrating that the CNV is predominantly classic (greater than or equal to 50%).

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the fluorescein angiogram.

Note The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Note A patient is eligible for a total of 15 subsidised treatments per eye. This maximum includes treatments administered under the MBS Visudyne Therapy Program and the PBS.

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be predominantly classic (greater than or equal to 50%), **AND**
- The condition must be due to macular degeneration, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

- Must be treated by an ophthalmologist.

Note A patient is eligible for a total of 15 subsidised treatments per eye. This maximum includes treatments administered under the MBS Visudyne Therapy Program and the PBS.

Note Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

verteporfin 15 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1349B	1	..	..	2142.00	39.50	Visudyne [NV]

OTHER OPHTHALMOLOGICALS

Other ophthalmologicals

▪ CARBOMER-974

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

carbomer-974 0.3% eye gel, 30 x 500 mg unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5502N OP	3	5	..	*35.56	36.77	Poly Gel [NV]

carbomer-974 0.3% eye gel, 30 x 500 mg unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8514D NP	3	5	..	*35.56	36.77	Poly Gel [NV]

▪ CARBOMER-980

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carbomer-980 0.2% eye gel, 10 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5503P OP	‡1	5	..	13.91	15.12	[a] Optifresh eye gel [PP]	[a] PAA [IA]

			[B]3.85	17.76	15.12	[a] Viscotears [IV]	

carbomer-980 0.2% eye gel, 10 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
8384G NP	‡1	5	..	13.91	15.12	[a] Optifresh eye gel [PP]	[a] PAA [IA]
			[B]3.85	17.76	15.12	[a] Viscotears [IV]	

▪ CARBOMER-980

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

carbomer-980 0.2% eye drops, 30 x 0.6 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5504Q OP	3	5	..	*36.88	38.09	Viscotears Gel PF [IV]

carbomer-980 0.2% eye drops, 30 x 0.6 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8578L NP	3	5	..	*36.88	38.09	Viscotears Gel PF [IV]

▪ CARBOMER-980

Note No applications for increased maximum quantities will be authorised.

Note No applications for repeats will be authorised.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

carbomer-980 0.2% eye gel, 10 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
9210R	‡1	11	..	13.91	15.12	[a] Optifresh eye gel [PP]	[a] PAA [IA]
			[B]3.85	17.76	15.12	[a] Viscotears [IV]	

▪ CARMELLOSE SODIUM

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5508X OP	‡1	5	..	14.54	15.75	Refresh Liquigel [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5507W OP	‡1	5	..	14.54	15.75	Refresh Tears Plus [AG]

▪ CARMELLOSE SODIUM

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8593G NP	‡1	5	..	14.54	15.75	Refresh Liquigel [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8548X NP	‡1	5	..	14.54	15.75	Refresh Tears Plus [AG]

▪ CARMELLOSE SODIUM

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

2324H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*31.63	32.84	[a] Optifresh Plus [PP]
			[B]7.29	*38.92	32.84	[a] Celluvisc [AG]

carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

5505R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	3	5	..	*31.63	32.84	[a] Optifresh Plus [PP]
			[B]7.29	*38.92	32.84	[a] Celluvisc [AG]

carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses

5510B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	3	5	..	*33.94	35.15	TheraTears [CX]

carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses

8824K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*33.94	35.15	TheraTears [CX]

carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses

5509Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	4	5	..	*39.19	39.50	TheraTears [CX]

carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses

8823J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*39.19	39.50	TheraTears [CX]

carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

2338C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*31.63	32.84	[a] Optifresh Tears [PP]
			[B]7.29	*38.92	32.84	[a] Cellufresh [AG]

carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

5506T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	3	5	..	*31.63	32.84	[a] Optifresh Tears [PP]
			[B]7.29	*38.92	32.84	[a] Cellufresh [AG]

▪ CARMELLOSE SODIUM

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome
Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

9212W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.54	15.75	Refresh Liquigel [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

9211T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.54	15.75	Refresh Tears Plus [AG]

▪ CARMELLOSE SODIUM + GLYCEROL

Note The in-use shelf life of Optive is 6 months from the date of opening.

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

5556K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	3	..	14.54	15.75	Optive [AG]

▪ CARMELLOSE SODIUM + GLYCEROL

Note The in-use shelf life of Optive is 6 months from the date of opening.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

9355J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	3	..	14.54	15.75	Optive [AG]

▪ CARMELLOSE SODIUM + GLYCEROL

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note The in-use shelf life of Optive is 6 months from the date of opening.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

9356K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	7	..	14.54	15.75	Optive [AG]

▪ DEXTRAN-70 + HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

1509K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.63	15.84	[a] Poly-Tears [NM]
			[B]3.65	18.28	15.84	[a] Tears Naturale [NV]

▪ DEXTRAN-70 + HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

5520M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.63	15.84	[a] Poly-Tears [NM]
			[B]3.65	18.28	15.84	[a] Tears Naturale [NV]

▪ DEXTRAN-70 + HYPROMELLOSE

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses

5521N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	3	5	..	*35.98	37.19	Bion Tears [NV]

dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses

8299T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*35.98	37.19	Bion Tears [NV]

▪ DEXTRAN-70 + HYPROMELLOSE

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

9216C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.63	15.84	[a] Poly-Tears [NM]
			[B]3.65	18.28	15.84	[a] Tears Naturale [NV]

▪ HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

8287E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	[a] In a Wink Moisturising [NM]
			[B]4.34	18.78	15.65	[a] Genteal [NV]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

2956N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	Methopt [QA]

▪ HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

5518K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	[a] In a Wink Moisturising [NM]
			[B]4.34	18.78	15.65	[a] Genteal [NV]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

5517J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	Methopt [QA]

▪ HYPROMELLOSE

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

9213X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.44	15.65	[a] In a Wink Moisturising [NM]
			[B]4.34	18.78	15.65	[a] Genteal [NV]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

9214Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.44	15.65	Methopt [QA]

▪ HYPROMELLOSE + CARBOMER-980

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

5519L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	[a] HPMC PAA [NM]
			[B]4.34	18.78	15.65	[a] Genteal gel [NV]

▪ HYPROMELLOSE + CARBOMER-980

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

8564R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	[a] HPMC PAA [NM]
			[B]4.34	18.78	15.65	[a] Genteal gel [NV]

▪ HYPROMELLOSE + CARBOMER-980

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Clinical criteria:

- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

9215B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.44	15.65	[a] HPMC PAA [NM]
			[B]4.34	18.78	15.65	[a] Genteal gel [NV]

▪ OCRIPLASMIN

Note Where authority approval for treatment for both eyes simultaneously is being sought, a maximum quantity of 2 vials may be requested.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Vitreomacular traction syndrome

Clinical criteria:

- Patient must have visual impairment due to vitreomacular traction (VMT) without a full thickness macular hole (FTMH); OR
- Patient must have visual impairment due to vitreomacular traction (VMT) with a full thickness macular hole (FTMH) of a diameter of less than or equal to 400 micrometres, **AND**
- Patient must have documented visual impairment defined as a best corrected visual acuity score of approximate Snellen equivalent 20/25 or worse in the eye proposed for treatment, **AND**
- The condition must be diagnosed by optical coherence tomography, **AND**
- The condition must have a vitreomacular adhesion diameter less than or equal to 1500 micrometres, **AND**
- Patient must not have an epiretinal membrane attached to the vitreomacular traction, **AND**
- The condition must be previously untreated in the eye proposed for treatment, **AND**
- Patient must not have received prior vitrectomy in the eye proposed for treatment, **AND**
- Patient must be symptomatic.

Treatment criteria:

- Must be treated by an ophthalmologist.

The prescriber must state which eye(s) is being treated at the time of application.

ocriplasmin 500 microgram/0.2 mL injection, 0.2 mL vial

10947E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	4149.52	39.50	Jetrea [NV]

▪ PARAFFIN

paraffin 1 g/g eye ointment, 3.5 g

1754H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*23.97	25.18	Poly Visc [NV]

paraffin 1 g/g eye ointment, 3.5 g

5523Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	2	5	..	*23.97	25.18	Poly Visc [NV]

paraffin 1 g/g eye ointment, 2 x 3.5 g

1750D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	23.42	24.63	Poly Visc [NV] [a] Ircal [PE]
			[B]1.84	25.26	24.63	[a] Refresh Night Time [AG]

paraffin 1 g/g eye ointment, 2 x 3.5 g

5522P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	23.42	24.63	Poly Visc [NV] [a] Ircal [PE]
			[B]1.84	25.26	24.63	[a] Refresh Night Time [AG]

▪ PARAFFIN

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

paraffin 1 g/g eye ointment, 2 x 3.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9218E	‡1	11	..	23.42	24.63	Poly Visc [NV]
						[a] Ircal [PE]
			[B]1.84	25.26	24.63	[a] Refresh Night Time [AG]

▪ PARAFFIN

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

paraffin 1 g/g eye ointment, 3.5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9217D	2	11	..	*23.97	25.18	Poly Visc [NV]

▪ PARAFFIN

Note The in-use shelf life of VitA-POS is 6 months from the date of opening.

paraffin + retinol palmitate 0.0138% eye ointment, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2167C	2	5	..	*23.97	25.18	VitA-POS [AE]

OP

paraffin + retinol palmitate 0.0138% eye ointment, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2222Y	2	5	..	*23.97	25.18	VitA-POS [AE]

NP

▪ PARAFFIN

Note The in-use shelf life of VitA-POS is 6 months from the date of opening.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

paraffin + retinol palmitate 0.0138% eye ointment, 5 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2202X	2	11	..	*23.97	25.18	VitA-POS [AE]

▪ POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5524R	‡1	5	..	14.54	15.75	Systane [NV]

OP

▪ POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8676P	‡1	5	..	14.54	15.75	Systane [NV]

NP

▪ POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5532E	2	5	..	*33.95	35.16	Systane [NV]

OP

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses

9170P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*33.95	35.16	Systane [NV]

▪ POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome
Clinical criteria:
- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

9219F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.54	15.75	Systane [NV]

▪ POLYVINYL ALCOHOL

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome

polyvinyl alcohol 1.4% eye drops, 15 mL

2682E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	[a] PVA Tears [PE]
			[B]1.39	15.83	15.65	[a] Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

8831T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	Vistil [AE]

polyvinyl alcohol 3% eye drops, 15 mL

8832W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	5	..	14.44	15.65	Vistil Forte [AE]

▪ POLYVINYL ALCOHOL

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome

polyvinyl alcohol 1.4% eye drops, 15 mL

5526W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	[a] PVA Tears [PE]
			[B]1.39	15.83	15.65	[a] Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

5527X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	Vistil [AE]

polyvinyl alcohol 3% eye drops, 15 mL

5528Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	5	..	14.44	15.65	Vistil Forte [AE]

▪ POLYVINYL ALCOHOL

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Severe dry eye syndrome, including Sjogren's syndrome
Clinical criteria:
- Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

polyvinyl alcohol 1.4% eye drops, 15 mL

9220G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	11	..	14.44	15.65	[a] PVA Tears [PE]
			[B]1.39	15.83	15.65	[a] Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9221H	‡1	11	..	14.44	15.65	Vistil [AE]

polyvinyl alcohol 3% eye drops, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9223K	‡1	11	..	14.44	15.65	Vistil Forte [AE]

▪ SODIUM HYALURONATE

Note The in-use shelf life of Hylo-Fresh and Hylo-Forte is 6 months from the date of opening.

Authority required (STREAMLINED)

4105

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2181T NP	‡1	5	..	34.74	35.95	Hylo-Fresh [AE]

sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2184Y OP	‡1	5	..	34.74	35.95	Hylo-Fresh [AE]

sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2171G OP	‡1	5	..	34.74	35.95	Hylo-Forte [AE]

sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2253N NP	‡1	5	..	34.74	35.95	Hylo-Forte [AE]

▪ SOY LECITHIN + TOCOPHEROL + VITAMIN A

Authority required (STREAMLINED)

6172

Severe dry eye syndrome

Clinical criteria:

- Patient must be sensitive to preservatives in multi-dose eye drops.

soy lecithin 1% + tocopherol 0.002% + vitamin A palmitate 0.025% eye spray, 100 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5545W OP	2	5	..	*35.59	36.80	tearsagain [RB]

soy lecithin 1% + tocopherol 0.002% + vitamin A palmitate 0.025% eye spray, 100 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9448G NP	2	5	..	*35.59	36.80	tearsagain [RB]

▪ OTOLOGICALS

ANTIINFECTIVES

Antiinfectives

▪ CIPROFLOXACIN

Authority required

Chronic suppurative otitis media

Population criteria:

- Patient must be an Aboriginal or a Torres Strait Islander person, **AND**
- Patient must be aged 1 month or older.

Authority required

Chronic suppurative otitis media

Population criteria:

- Patient must be less than 18 years of age.

Clinical criteria:

- Patient must have perforation of the tympanic membrane.

Authority required

Chronic suppurative otitis media

Population criteria:

- Patient must be less than 18 years of age.

Clinical criteria:

- Patient must have a grommet in situ.

ciprofloxacin 0.3% ear drops, 5 mL

2480M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	1	..	22.27	23.48	Ciloxan [NV]

CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION

Corticosteroids and antiinfectives in combination

▪ FRAMYCETIN SULFATE + GRAMICIDIN + DEXAMETHASONE

framycetin sulfate 0.5% + gramicidin 0.005% + dexamethasone 0.05% ear drops, 8 mL

2781J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	14.15	15.36	[a] Otodex [AV]
			[B]1.66	15.81	15.36	[a] Sofradex [SW]

▪ TRIAMCINOLONE + NEOMYCIN SULFATE + GRAMICIDIN + NYSTATIN

triamcinolone acetonide 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/mL ear drops, 7.5 mL

2971J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	15.15	16.36	[a] Otocomb Otic [FM]
			[B]1.70	16.85	16.36	[a] Kenacomb Otic [QA]

triamcinolone acetonide 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/g ointment, 5 g

2974M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	2	..	12.62	13.83	[a] Otocomb Otic [FM]
			[B]1.70	14.32	13.83	[a] Kenacomb Otic [QA]

▪ OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS

ANTIINFECTIVES

Antiinfectives

▪ FRAMYCETIN SULFATE

framycetin sulfate 0.5% eye/ear drops, 8 mL

1440T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP MW	‡1	2	..	14.67	15.88	Soframycin [SW]

framycetin sulfate 0.5% eye/ear drops, 8 mL

5557L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
OP	‡1	2	..	14.67	15.88	Soframycin [SW]

▪ VARIOUS

▪ ALLERGENS

ALLERGENS

Allergen extracts

▪ HONEY BEE VENOM

bee venom 550 microgram injection [1 vial] (&) inert substance diluent [9 mL vial] (&) inert substance diluent [3 x 1.8 mL vials], 1 pack

2886X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	264.51	39.50	Albey Bee Venom [DE]

bee venom 550 microgram injection [1 vial] (&) inert substance diluent [9 mL vial], 1 pack

10621B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	264.51	39.50	Hymenoptera Honey Bee Venom [DE]

▪ PAPER WASP VENOM

Note Paper wasp venom is not European wasp venom

paper wasp venom 550 microgram injection [1 vial] (&) inert substance diluent [9 mL vial] (&) inert substance diluent [3 x 1.8 mL vials], 1 pack

2918N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	264.51	39.50	Albey Paper Wasp Venom [DE]

▪ VESPULA SPP VENOM

vespula spp venom 550 microgram injection [1 vial] (&) inert substance diluent [9 mL vial] (&) inert substance diluent [3 x 1.8 mL vials], 1 pack

2883R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	264.51	39.50	Albey Yellow Jacket Venom [DE]

▪ ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Antidotes

▪ NALOXONE

naloxone hydrochloride 400 microgram/mL injection, 5 x 1 mL ampoules

10783M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	82.48	39.50	[a] Naloxone Hydrochloride (DBL) [PF]	[a] Naloxone Juno [JU]

naloxone hydrochloride 400 microgram/mL injection, 5 x 1 mL ampoules

10787R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	82.48	39.50	[a] Naloxone Hydrochloride (DBL) [PF]	[a] Naloxone Juno [JU]

naloxone hydrochloride 1 mg/ mL injection, 1 x 2 mL syringe

11077B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
DP	1	..	..	74.05	39.50	Prenoxad [PL]

naloxone hydrochloride 1 mg/ mL injection, 1 x 2 mL syringe

11078C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	74.05	39.50	Prenoxad [PL]

Drugs for treatment of hyperkalemia and hyperphosphatemia

▪ LANTHANUM

Note Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5491

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

9405B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	475.25	39.50	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

9404Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	422.68	39.50	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

9403X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	281.53	39.50	Fosrenol [ZI]

▪ SEVELAMER

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5491

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

sevelamer hydrochloride 800 mg tablet, 180

2142R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	332.52	39.50	Renagel [GZ]

▪ SUCROFERRIC OXYHYDROXIDE

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required (STREAMLINED)

5491

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

iron (as sucroferric oxyhydroxide) 500 mg tablet: chewable, 90

10250L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	424.03	39.50	Velphoro [FN]

Detoxifying agents for antineoplastic treatment

▪ FOLINIC ACID

folinic acid 300 mg/30 mL injection, 30 mL vial

9041W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	1	..	*56.39	39.50	[a] Calcium Folinate Ebewe [SZ]	[a] Leucovorin Calcium (Hospira Pty Limited) [PF]

folinic acid 1 g/100 mL injection, 100 mL vial

8969C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	49.78	39.50	Calcium Folinate Ebewe [SZ]

▪ FOLINIC ACID

Note For item codes 8740B and 1610R, pharmaceutical benefits that have the form injection equivalent to 50 mg folinic acid in 5 mL are equivalent for the purposes of substitution.

folinic acid 50 mg/5 mL injection, 10 x 5 mL ampoules

1610R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	52.92	39.50	[a] Leucovorin Calcium (Pfizer Australia Pty Ltd) [PF]

folinic acid 50 mg/5 mL injection, 5 mL vial

8740B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	2	..	*52.85	39.50	[a] Leucovorin Calcium (Hospira Pty Limited) [PF]

▪ FOLINIC ACID

Note For item codes 8812T and 1704Q, pharmaceutical benefits that have the form injection equivalent to 100 mg folinic acid in 10 mL are equivalent for the purposes of substitution.

folinic acid 100 mg/10 mL injection, 10 mL vial

8812T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	1	..	*58.15	39.50	[a] Calcium Folinate Ebewe [SZ]

folinic acid 100 mg/10 mL injection, 10 x 10 mL ampoules

1704Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	58.18	39.50	[a] Leucovorin Calcium (Pfizer Australia Pty Ltd) [PF]

▪ FOLINIC ACID

Restricted benefit

Megaloblastic anaemias

Clinical criteria:

- The condition must be a result of folic acid deficiency from the use of folic acid antagonists.

folinic acid 15 mg tablet, 10

2308L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	92.81	39.50	Leucovorin Calcium (Hospira Pty Limited) [PF]

▪ MESNA

Restricted benefit

Urothelial toxicity

Treatment Phase: Prophylaxis or reduction of toxicity

Clinical criteria:

- The treatment must be adjunctive therapy to ifosfamide or high dose cyclophosphamide.

mesna 400 mg/4 mL injection, 15 x 4 mL ampoules

8078E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	94.74	39.50	Uromitexan [BX]

mesna 1 g/10 mL injection, 15 x 10 mL ampoules

8079F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	200.84	39.50	Uromitexan [BX]

Drugs for treatment of hypercalcemia

▪ PHOSPHORUS

Authority required (STREAMLINED)

5089

Hypophosphataemic rickets

Authority required (STREAMLINED)

5114

Vitamin D-resistant rickets

Authority required (STREAMLINED)

5095

Familial hypophosphataemia

Authority required (STREAMLINED)

5123

Hypercalcaemia

phosphorus 500 mg effervescent tablet, 100

2946C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	76.04	39.50	Phosphate Sandoz [PL]

Other therapeutic products

▪ POLYLACTIC ACID

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Authority applications may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required
Severe facial lipoatrophy
Treatment Phase: Initial PBS-subsidised treatment
Clinical criteria:

- The treatment must be for facial administration only, **AND**
- The condition must be caused by therapy for HIV infection.

Accreditation following completion of injection administration training with Galderma is required to prescribe poly-l-lactic acid under the PBS. Patients must be referred from the HIV physician to the accredited injector.

polylactic acid 150 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9475Q	2	4	..	*419.77	39.50	Sculptra [GA]

▪ POLYLACTIC ACID

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Maintenance treatment is limited to one re-treatment (maximum 2 vials) every 2 years.
Note Authority applications may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required
Severe facial lipoatrophy
Treatment Phase: Maintenance PBS-subsidised treatment
Clinical criteria:

- The treatment must be for facial administration only, **AND**
- The condition must be caused by therapy for HIV infection.

Accreditation following completion of injection administration training with Galderma is required to prescribe poly-l-lactic acid under the PBS. Patients must be referred from the HIV physician to the accredited injector.

polylactic acid 150 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9476R	2	..	..	*419.77	39.50	Sculptra [GA]

▪ DIAGNOSTIC AGENTS

URINE TESTS

▪ GLUCOSE AND KETONE INDICATOR URINE

Restricted benefit
For treatment of a patient identifying as Aboriginal or Torres Strait Islander

glucose and ketone indicator urine diagnostic strip, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3107M NP	2	2	..	*20.19	21.40	Keto-Diastix [BN]

▪ GLUCOSE INDICATOR URINE

Restricted benefit
For treatment of a patient identifying as Aboriginal or Torres Strait Islander

glucose indicator urine diagnostic strip, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3104J NP	2	2	..	*22.17	23.38	Diastix [BN]

▪ GENERAL NUTRIENTS

OTHER NUTRIENTS

▪ MEDIUM CHAIN TRIGLYCERIDES

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
6147

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

Authority required (STREAMLINED)

6191

Dietary management of conditions requiring a source of medium chain triglycerides

Clinical criteria:

- Patient must have chylous ascites; OR
- Patient must have chylothorax; OR
- Patient must have hyperlipoproteinaemia type 1; OR
- Patient must have long chain fatty acid oxidation disorders; OR
- Patient must have fat malabsorption due to liver disease; OR
- Patient must have fat malabsorption due to short gut syndrome; OR
- Patient must have fat malabsorption due to cystic fibrosis; OR
- Patient must have fat malabsorption due to gastrointestinal disorders.

triglycerides medium chain oral liquid, 18 x 250 mL cartons

10049X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*357.87	39.50	betaquik [VF]

▪ MEDIUM CHAIN TRIGLYCERIDES

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6181

Chylous ascites

Authority required (STREAMLINED)

6134

Chylothorax

Authority required (STREAMLINED)

6164

Fat malabsorption

Clinical criteria:

- The condition must be due to liver disease; OR
- The condition must be due to short gut syndrome; OR
- The condition must be due to cystic fibrosis; OR
- The condition must be due to gastrointestinal disorders.

Authority required (STREAMLINED)

6203

Hyperlipoproteinaemia type 1

Authority required (STREAMLINED)

6155

Intractable childhood epilepsy

Clinical criteria:

- Patient must require a ketogenic diet.

Authority required (STREAMLINED)

6135

Cerebrospinal fluid glucose transporter defect

Clinical criteria:

- Patient must require a ketogenic diet.

Authority required (STREAMLINED)

6146

Long chain fatty acid oxidation disorders

medium chain triglycerides oral liquid, 250 mL bottle

9327X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*191.63	39.50	Liquigen [SB]

medium chain triglycerides oral oil, 500 mL

3128P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*50.49	39.50	MCT Oil [SB]

▪ PROTEIN FORMULA WITH CARBOHYDRATE, FAT, VITAMINS AND MINERALS

Note No increase in the maximum number of repeats may be authorised.

Note Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

Restricted benefit

Dietary management of conditions requiring a source of medium chain triglycerides

Clinical criteria:

- Patient must have fat malabsorption due to liver disease; OR
- Patient must have fat malabsorption due to short gut syndrome; OR
- Patient must have fat malabsorption due to cystic fibrosis; OR
- Patient must have fat malabsorption due to gastrointestinal disorders.

Population criteria:

- Patient must be aged from 1 to 10 years inclusive.

protein formula with carbohydrate, fat, vitamins and minerals oral liquid, 8 x 500 mL pouches

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11110R NP	10	5	..	*1502.65	39.50	Nutrini Peptisorb Energy [NU]

▪ TRIGLYCERIDES LONG CHAIN

Note Carbzero is not nutritionally complete and is not intended for use as a sole source of nutrition.

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

Carbzero should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

triglycerides long chain oral liquid, 18 x 250 mL cartons

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10037G NP	2	5	..	*289.83	39.50	carbzero [VF]

Fat/carbohydrates/proteins/minerals/vitamins, combinations

▪ AMINO ACID SYNTHETIC FORMULA

Note Authorities for increased maximum quantities, up to a maximum of 52, may be authorised.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

- Patient must be 18 years of age or less.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

(i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and

(ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

- Patient must be 18 years of age or less.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

amino acid synthetic formula powder for oral liquid, 400 g

1521C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	12	5	..	*501.43	39.50	Neocate Advance Vanilla [SB]

amino acid synthetic formula powder for oral liquid, 400 g

2250K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	12	5	..	*501.43	39.50	EleCare [AB]

▪ AMINO ACID SYNTHETIC FORMULA

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

amino acid synthetic formula powder for oral liquid, 400 g

1180D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	Neocate Advance Vanilla [SB]

amino acid synthetic formula powder for oral liquid, 400 g

8574G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	EleCare [AB]

amino acid synthetic formula powder for oral liquid, 400 g

8754R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	Neocate Advance [SB]

▪ AMINO ACID SYNTHETIC FORMULA

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

amino acid synthetic formula powder for oral liquid, 400 g

1192R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	Neocate Advance Vanilla [SB]

amino acid synthetic formula powder for oral liquid, 400 g

8575H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	EleCare [AB]

amino acid synthetic formula powder for oral liquid, 400 g

8755T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*335.87	39.50	Neocate Advance [SB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids powder for oral liquid, 400 g

2246F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*342.43	39.50	Neocate LCP [SB]

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids powder for oral liquid, 400 g

9339M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*342.43	39.50	EleCare LCP [AB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids powder for oral liquid, 400 g

2560R

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*342.43	39.50	Neocate LCP [SB]

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids powder for oral liquid, 400 g

9340N

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*342.43	39.50	EleCare LCP [AB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Note Authorities for increased maximum quantities, up to a maximum of 52, may be authorised.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

- Patient must be 18 years of age or less.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

(i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and

(ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

- Patient must be 18 years of age or less.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides powder for oral liquid, 400 g

1545H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	12	5	..	*511.27	39.50	Neocate Gold [SB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required
Cows' milk protein enteropathy
Treatment Phase: Initial treatment for up to 6 months
Treatment criteria:
- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:
- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:
- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required
Severe cows' milk protein enteropathy with failure to thrive
Treatment Phase: Initial treatment for up to 6 months
Treatment criteria:
- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:
- The condition must not be isolated infant colic or reflux.

Population criteria:
- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required
Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae
Treatment Phase: Initial treatment for up to 6 months
Treatment criteria:
- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:
- The condition must not be isolated infant colic or reflux.

Population criteria:
- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required
Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein
Treatment Phase: Initial treatment for up to 6 months
Treatment criteria:
- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:
- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:
- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides powder for oral liquid, 400 g

5466Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*342.43	39.50	Neocate Gold [SB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides powder for oral liquid, 400 g

5467R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*342.43	39.50	Neocate Gold [SB]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

- Patient must be 18 years of age or less.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides powder for oral liquid, 400 g

2900P

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*342.43	39.50	Alfamino [NT]

▪ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

- Patient must be 18 years of age or less.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

(i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and

(ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides powder for oral liquid, 400 g

2928D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*342.43	39.50	Alfamino [NT]

NP

▪ PROTEIN HYDROLYSATE FORMULA WITH MEDIUM CHAIN TRIGLYCERIDES

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6174

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

- Patient must be up to the age of 24 months.

Authority required (STREAMLINED)

6193

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**

- Patient must have demonstrated a clinical improvement with the protein hydrolysate formula with medium chain triglycerides.

Population criteria:

- Patient must be up to the age of 24 months.

Authority required (STREAMLINED)

6204

Cows' milk protein enteropathy and intolerance to soy protein

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6137

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6182

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6194

Biliary atresia

Authority required (STREAMLINED)

6157

Chronic liver failure with fat malabsorption

Authority required (STREAMLINED)

6205

Chylous ascites

Authority required (STREAMLINED)

6195

Cystic fibrosis

Authority required (STREAMLINED)

6158

Enterokinase deficiency

Authority required (STREAMLINED)

6166

Proven fat malabsorption

Authority required (STREAMLINED)

6148

Severe diarrhoea of greater than 2 weeks duration

Population criteria:

- Patient must be aged less than 4 months.

Authority required (STREAMLINED)

6138

Severe intestinal malabsorption including short bowel syndrome

protein hydrolysate formula with medium chain triglycerides powder for oral liquid, 450 g

8259Q

NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*100.35	39.50	Aptamil Gold+ Pepti-Junior [NU]

▪ PROTEIN HYDROLYSATE FORMULA WITH MEDIUM CHAIN TRIGLYCERIDES

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6174

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

- Patient must be up to the age of 24 months.

Authority required (STREAMLINED)

6193

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have demonstrated a clinical improvement with the protein hydrolysate formula with medium chain triglycerides.

Population criteria:

- Patient must be up to the age of 24 months.

Authority required (STREAMLINED)

6204

Cows' milk protein enteropathy and intolerance to soy protein

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6137

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6182

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist must be documented in the patient's medical records

Authority required (STREAMLINED)

6194

Biliary atresia

Authority required (STREAMLINED)

6157

Chronic liver failure with fat malabsorption
Authority required (STREAMLINED)
6205
Chylous ascites
Authority required (STREAMLINED)
6195
Cystic fibrosis
Authority required (STREAMLINED)
6158
Enterokinase deficiency
Authority required (STREAMLINED)
6166
Proven fat malabsorption
Authority required (STREAMLINED)
6148
Severe diarrhoea of greater than 2 weeks duration
Population criteria:
- Patient must be aged less than 4 months.

Authority required (STREAMLINED)
6138
Severe intestinal malabsorption including short bowel syndrome
Authority required (STREAMLINED)
6206
Chylothorax

protein hydrolysate formula with medium chain triglycerides powder for oral liquid, 400 g

2676W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*154.03	39.50	Alfaré [NT]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA

Note No increase in the maximum number of repeats may be authorised.
Note No increase in the maximum quantity or number of units may be authorised.
Note Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

Restricted benefit
Dietary management of conditions requiring a source of medium chain triglycerides
Clinical criteria:
- Patient must have fat malabsorption due to liver disease; OR
- Patient must have fat malabsorption due to short gut syndrome; OR
- Patient must have fat malabsorption due to cystic fibrosis; OR
- Patient must have fat malabsorption due to gastrointestinal disorders.

triglycerides medium chain formula oral liquid, 8 x 500 mL pouches

10375C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*824.43	39.50	Nutrini Peptisorb [SB]

triglycerides medium chain formula powder for oral liquid, 400 g

10152H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*394.99	39.50	Monogen [SB]

triglycerides medium chain formula powder for oral liquid, 400 g

10155L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*416.11	39.50	Lipistart [VF]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA

Note No increase in the maximum number of repeats may be authorised.
Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.
Note Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

Restricted benefit
Dietary management of conditions requiring a source of medium chain triglycerides
Clinical criteria:
- Patient must have fat malabsorption due to liver disease; OR
- Patient must have fat malabsorption due to short gut syndrome; OR
- Patient must have fat malabsorption due to cystic fibrosis; OR
- Patient must have fat malabsorption due to gastrointestinal disorders.

triglycerides medium chain formula powder for oral liquid, 400 g

10154K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*385.31	39.50	Peptamen Junior [NT]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA

Note No increase in the maximum number of repeats may be authorised.

Note No increase in the maximum quantity or number of units may be authorised.

Note Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

Restricted benefit

Hyperlipoproteinaemia type 1

Restricted benefit

Long chain fatty acid oxidation disorders

Restricted benefit

Chylous ascites

Restricted benefit

Chylothorax

triglycerides medium chain formula powder for oral liquid, 400 g

1938B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*416.11	39.50	Lipistart [VF]

triglycerides medium chain formula powder for oral liquid, 400 g

8478F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*394.99	39.50	Monogen [SB]

Carbohydrates

▪ MODIFIED LONG CHAIN AMYLOPECTIN

Restricted benefit

Glycogen storage disease

modified long chain amylopectin powder for oral liquid, 30 x 60 g sachets

9386B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*709.95	39.50	Glycosade [VF]

Amino acids/carbohydrates/minerals/vitamins, combinations

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS, TRACE ELEMENTS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

- Patient must be 18 years of age or less.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

(i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and

(ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid formula with fat, carbohydrate, vitamins, minerals, trace elements and medium chain triglycerides oral liquid: powder for, 400 g

10522T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8	5	..	*353.31	39.50	Alfamino Junior [NT]

NP

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS, TRACE ELEMENTS AND MEDIUM CHAIN TRIGLYCERIDES

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**

- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

- Patient must be 18 years of age or less.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

amino acid formula with fat, carbohydrate, vitamins, minerals, trace elements and medium chain triglycerides oral liquid: powder for, 400 g

10527C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*353.31	39.50	Alfamino Junior [NT]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS, TRACE ELEMENTS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

- Patient must be 18 years of age or less.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

(i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and

(ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid formula with fat, carbohydrate, vitamins, minerals, trace elements and medium chain triglycerides powder for oral liquid, 400 g

11161K

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*353.31	39.50	Neocate Junior [SB]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS, TRACE ELEMENTS AND MEDIUM CHAIN TRIGLYCERIDES

Note Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

Clinical criteria:

- The condition must not be isolated infant colic or reflux, **AND**
- Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

Clinical criteria:

- The condition must not be isolated infant colic or reflux.

Population criteria:

- Patient must be older than 24 months of age.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

Clinical criteria:

- Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

- Patient must be up to the age of 24 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk anaphylaxis

Treatment criteria:

- Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Population criteria:

- Patient must be up to the age of 24 months.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

- Patient must have failed to respond to protein hydrolysate formulae; OR
- Patient must have been receiving parenteral nutrition.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Clinical criteria:

- Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

- Patient must be 18 years of age or less.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

amino acid formula with fat, carbohydrate, vitamins, minerals, trace elements and medium chain triglycerides powder for oral liquid, 400 g

11183N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*353.31	39.50	Neocate Junior [SB]

Milk substitutes

▪ MILK POWDER LACTOSE FREE FORMULA PREDIGESTED

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note No more than 1 application per patient will be authorised.

Authority required

Acute lactose intolerance

Population criteria:

- Patient must be up to the age of 12 months.

The date of birth of the patient must be provided at the time of application.

milk powder lactose free formula predigested powder for oral liquid, 900 g

2975N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	..	..	*88.00	39.50	Aptamil Gold+ De-Lact [NU]

▪ MILK POWDER LACTOSE INTOLERANCE FORMULA

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note No more than 1 application per patient will be authorised.

Authority required

Acute lactose intolerance

Population criteria:

- Patient must be up to the age of 12 months.

The date of birth of the patient must be provided at the time of application.

milk powder lactose intolerance formula powder for oral liquid, 900 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11209Y NP	5	..	..	*103.05	39.50	S-26 Original LI [AS]

▪ MILK POWDER SYNTHETIC LOW CALCIUM

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Restricted benefit
Hypercalcaemia
Population criteria:
- Patient must be under the age of 4 years.

milk powder synthetic low calcium powder for oral liquid, 400 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3092R NP	8	5	..	*355.87	39.50	Locasol [SB]

Other combinations of nutrients

▪ AMINO ACID FORMULA WITH CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE

Restricted benefit
Phenylketonuria

amino acid formula with carbohydrate, vitamins, minerals and trace elements without phenylalanine oral liquid: powder for, 30 x 20 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10806R NP	4	5	..	*1000.43	39.50	PKU Go [OH]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE WITHOUT PHENYLALANINE

Restricted benefit
Phenylketonuria

amino acid formula with fat, carbohydrate without phenylalanine tablet: modified release, 4 x 110 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10683G NP	7	5	..	*1929.63	39.50	PKU Easy Microtabs [OH]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit
Phenylketonuria

amino acid formula with fat, carbohydrate, vitamins, minerals and long chain polyunsaturated fatty acids without phenylalanine and supplemented with docosahexaenoic acid oral liquid, 20 x 500 mL bottles

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10822N NP	2	5	..	*633.75	39.50	PKU Baby [OH]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit
Pyridoxine non-responsive homocystinuria

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without methionine and supplemented with docosahexaenoic acid oral liquid, 36 x 125 mL cans

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3417W NP	4	5	..	*2393.07	39.50	HCU Anamix junior LQ [SB]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE

Restricted benefit
Phenylketonuria

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without phenylalanine oral liquid: powder for, 30 x 34 g bottles

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10632N NP	5	5	..	*1905.85	39.50	PKU Easy Shake & Go [OH]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE

Restricted benefit

Tyrosinaemia

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without phenylalanine and tyrosine oral liquid: powder for, 30 x 34 g bottles

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10934L NP	4	5	..	*2953.95	39.50	TYR Easy Shake & Go [OH]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit

Tyrosinaemia

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without phenylalanine and tyrosine, and supplemented with docosahexaenoic acid oral liquid, 36 x 125 mL cans

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9330C NP	4	5	..	*2393.07	39.50	TYR Anamix junior LQ [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

Proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan powder for oral liquid, 30 x 18 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10715Y NP	8	5	..	*2012.19	39.50	GA1 Anamix Junior [NU]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

Proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan powder for oral liquid, 30 x 25 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5484P NP	4	5	..	*3007.19	39.50	GA express 15 [VF]

amino acid formula with vitamins and minerals without lysine and low in tryptophan powder for oral liquid, 400 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2650L NP	8	5	..	*726.03	39.50	GA1 Anamix infant [SB]

amino acid formula with vitamins and minerals without lysine and low in tryptophan powder for oral liquid, 500 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10466W NP	9	5	..	*2935.75	39.50	XLYS, LOW TRY Maxamum [SB]

amino acid formula with vitamins and minerals without lysine and low in tryptophan powder for oral liquid, 30 x 24 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9438R NP	4	5	..	*2012.23	39.50	GA gel [VF]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE

Restricted benefit

Pyridoxine non-responsive homocystinuria

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 174 mL sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2640Y NP	4	5	..	*3888.75	39.50	HCU cooler 20 [VF]

AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE Oral liquid 125 mL, 30, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1548L NP	3	5	..	*2953.90	39.50	HCU Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without methionine powder for oral liquid, 500 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8416Y NP	8	5	..	*2579.95	39.50	XMET Maxamum [SB]

amino acid formula with vitamins and minerals without methionine powder for oral liquid, 30 x 24 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8677Q NP	4	5	..	*2012.23	39.50	HCU gel [VF]

amino acid formula with vitamins and minerals without methionine powder for oral liquid, 30 x 25 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8744F NP	4	5	..	*2953.95	39.50	HCU express 15 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 130 mL cans

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9133Q NP	4	5	..	*2953.95	39.50	HCU cooler 15 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 87 mL sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2639X NP	4	5	..	*2012.23	39.50	HCU cooler 10 [VF]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE

Restricted benefit

Pyridoxine non-responsive homocystinuria

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 36 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10693T NP	4	5	..	*2012.23	39.50	HCU Anamix Junior [NU]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE

Restricted benefit

Pyridoxine non-responsive homocystinuria

Population criteria:

- Patient must be an infant or a very young child.

amino acid formula with vitamins and minerals without methionine powder for oral liquid, 400 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8417B NP	8	5	..	*726.03	39.50	HCU Anamix infant [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE

Restricted benefit

Methylmalonic acidaemia

Restricted benefit

Propionic acidaemia

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine powder for oral liquid, 30 x 25 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3443F NP	4	5	..	*2953.95	39.50	MMA/PA express 15 [VF]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine powder for oral liquid, 30 x 24 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3444G NP	4	5	..	*2012.23	39.50	MMA/PA gel [VF]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine powder for oral liquid, 500 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8061G NP	8	5	..	*2579.95	39.50	XMTVI Maxamum [SB]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine powder for oral liquid, 400 g

8058D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*726.03	39.50	MMA/PA Anamix infant [SB]

AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE, THREONINE and VALINE and low in ISOLEUCINE Oral liquid 130 mL, 30, 1

1923F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2953.95	39.50	MMA/PA cooler 15 [VF]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE

Restricted benefit
Methylmalonic acidaemia
Restricted benefit
Propionic acidaemia

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 30 x 18 g sachets

10730R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*2012.19	39.50	MMA/PA Anamix Junior [NU]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE

Restricted benefit
Phenylketonuria

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 174 mL pouch

10411Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1952.87	39.50	PKU Air 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 30 x 24 g sachets

8555G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1000.43	39.50	PKU gel [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 87 mL cans

2382J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*976.99	39.50	PKU Cooler 10 [VF]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 500 g

2738D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*834.51	39.50	XP Maxamaid [SB]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 500 g

2739E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*1280.99	39.50	XP Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 130 mL cans

8846N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1466.15	39.50	PKU Cooler 15 [VF]

AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 34 g, 30, 1

1909L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1952.87	39.50	PKU express 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 130 mL pouch

10410X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1466.15	39.50	PKU Air 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 60 x 62.5 mL cans

9397N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*1001.21	39.50	PKU Lophlex LQ 10 [SB]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 30 x 25 g sachets

8591E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1466.95	39.50	PKU express 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral semi-solid, 36 x 109 g jars

2806Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*1754.98	39.50	PKU Lophlex Sensation 20 [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 125 mL cans

9021T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1930.63	39.50	PKU Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 30 x 50 g sachets

8727H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*1431.91	39.50	XP Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine powder for oral liquid, 30 x 27.8 g sachets

8804J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1930.63	39.50	PKU Lophlex [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 36 x 125 mL cans

9396M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1202.91	39.50	PKU Anamix Junior LQ [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 18 x 250 mL

8746H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	5	..	*1243.95	39.50	Easiphen [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 174 mL cans

2474F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1952.87	39.50	PKU Cooler 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 85 g sachets

5483N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1000.43	39.50	PKU squeezie [VF]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE

Note Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

Restricted benefit
Phenylketonuria

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 36 g sachets

10258X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1001.63	39.50	PKU Anamix Junior [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE

Restricted benefit
Tyrosinaemia

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 130 mL cans

9132P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2953.95	39.50	TYR cooler 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 174 mL sachets

2701E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*3888.75	39.50	TYR cooler 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine powder for oral liquid, 30 x 34 g sachets

11151X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*3888.75	39.50	TYR express 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine powder for oral liquid, 30 x 24 g sachets

8631G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	TYR gel [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine powder for oral liquid, 30 x 25 g sachets

8667E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2953.95	39.50	TYR express 15 [VF]

AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE and TYROSINE Oral liquid 125 mL, 30, 1

1547K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*2953.90	39.50	TYR Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 87 mL sachets

2674R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	TYR cooler 10 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine powder for oral liquid, 500 g

3078B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*2579.95	39.50	XPhen, Tyr Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine powder for oral liquid, 400 g

8445L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*726.03	39.50	TYR Anamix infant [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE

Note Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

Restricted benefit
Tyrosinaemia

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 36 g sachets

10260B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	TYR Anamix Junior [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE

Restricted benefit
Maple syrup urine disease

AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Sachets 34 g, 30, 1

1914R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*3899.91	39.50	MSUD express 20 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 130 mL cans

2375B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2953.95	39.50	MSUD cooler 15 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 174 mL pouches

2654Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*3888.75	39.50	MSUD cooler 20 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine powder for oral liquid, 500 g

8057C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*2579.95	39.50	MSUD Maxamum [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine powder for oral liquid, 500 g

8310J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2548.87	39.50	MSUD AID III [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 87 mL pouches

2651M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	MSUD cooler 10 [VF]

AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Oral liquid 125 mL, 30, 1

1546J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	5	..	*2953.90	39.50	MSUD Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine powder for oral liquid, 30 x 24 g sachets

8592F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	MSUD gel [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine powder for oral liquid, 30 x 25 g sachets

8632H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2953.95	39.50	MSUD express 15 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine powder for oral liquid, 400 g

2380G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*726.03	39.50	MSUD Anamix infant [SB]

- **AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE**

Note Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

Restricted benefit

Maple syrup urine disease

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 36 g sachets

10259Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2012.23	39.50	MSUD Anamix Junior [SB]

- **AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE WITH FAT, CARBOHYDRATE AND TRACE ELEMENTS AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID**

Restricted benefit

Maple syrup urine disease

amino acid formula with vitamins and minerals without valine, leucine and isoleucine with fat, carbohydrate and trace elements and supplemented with docosahexaenoic acid oral liquid, 36 x 125 mL cans

9499Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*2393.07	39.50	MSUD Anamix Junior LQ [SB]

- **AMINO ACID FORMULA WITH VITAMINS AND MINERALS, LOW PHENYLALANINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID AND ARACHIDONIC ACID**

Restricted benefit

Phenylketonuria

amino acid formula with vitamins and minerals, low phenylalanine and supplemented with docosahexaenoic acid and arachidonic acid powder for oral liquid, 30 x 12.5 g sachets

11185Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*1000.35	39.50	PKU Anamix First Spoon [SB]

- **AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE**

Restricted benefit

Phenylketonuria

amino acid formula with vitamins, minerals and long chain polyunsaturated fatty acids without phenylalanine powder for oral liquid, 400 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8479G NP	8	5	..	*663.95	39.50	PKU Anamix infant [SB]

▪ AMINO ACID FORMULA WITHOUT PHENYLALANINE

Restricted benefit

Phenylketonuria

amino acid formula without phenylalanine powder for oral liquid, 30 x 20 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2347M NP	7	5	..	*1385.45	39.50	Phlexy-10 Drink Mix [SB]

amino acid formula without phenylalanine 500 mg capsule, 200

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8554F NP	16	5	..	*1209.07	39.50	Phlexy-10 [SB]

amino acid formula without phenylalanine 1 g tablet, 75

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8678R NP	24	5	..	*1351.39	39.50	Phlexy-10 [SB]

▪ AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE

Restricted benefit

Maple syrup urine disease

amino acid formula without valine, leucine and isoleucine containing 5 g of protein equivalent oral liquid: powder for, 30 x 6 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10161T NP	12	5	..	*3101.59	39.50	MSUD amino5 [VF]

▪ ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE

Restricted benefit

Peroxisomal biogenesis disorders

arachidonic acid and docosahexaenoic acid with carbohydrate containing 200 mg arachidonic acid and 100 mg docosahexaenoic acid oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10036F NP	4	5	..	*363.31	39.50	keyomega [VF]

▪ ARGININE WITH CARBOHYDRATE

Note Arginine with carbohydrate is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism.

Restricted benefit

Urea cycle disorders

arginine with carbohydrate containing 2 g arginine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5482M NP	4	5	..	*727.51	39.50	Arginine 2000 [VF]

arginine with carbohydrate containing 500 mg arginine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9437Q NP	4	5	..	*486.55	39.50	Arginine 500 [VF]

arginine with carbohydrate containing 5 g arginine oral liquid: powder for, 30 x 7.6 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10093F NP	4	5	..	*966.03	39.50	Arginine 5000 [VF]

▪ CARBOHYDRATE, FAT, VITAMINS, MINERALS AND TRACE ELEMENTS

Restricted benefit

Proven inborn errors of protein metabolism

Clinical criteria:

- Patient must be unable to meet their energy requirements with permitted food and formulae.

carbohydrate, fat, vitamins, minerals and trace elements powder for oral liquid, 400 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
8369L NP	8	5	..	*293.63	39.50	Energivit [SB]

▪ CARBOHYDRATES, FAT, VITAMINS, MINERALS, TRACE ELEMENTS AND SUPPLEMENTED WITH ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID

Restricted benefit

Proven inborn errors of protein metabolism

Clinical criteria:

- Patient must be unable to meet their energy requirements with permitted food and formulae.

carbohydrates, fat, vitamins, minerals, trace elements and supplemented with arachidonic acid and docosahexaenoic acid providing 200 kilocalories powder for oral liquid, 30 x 43 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10039J NP	4	5	..	*468.19	39.50	basecal 200 [VF]

carbohydrates, fat, vitamins, minerals, trace elements and supplemented with arachidonic acid and docosahexaenoic acid providing 100 kilocalories powder for oral liquid, 30 x 21.5 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10050Y NP	4	5	..	*236.47	39.50	basecal 100 [VF]

▪ CITRULLINE

Note Citrulline is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism

Restricted benefit

Urea cycle disorders

Clinical criteria:

- The treatment must be for preventing low plasma arginine levels; OR
- The treatment must be for preventing low citrulline levels.

citrulline 1 g tablet, 300

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10736C NP	‡1	5	..	1197.40	39.50	Citrulline Easy [OH]

▪ CITRULLINE WITH CARBOHYDRATE

Note Citrulline with carbohydrate is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism.

Restricted benefit

Urea cycle disorders

Clinical criteria:

- The treatment must be for preventing low plasma arginine levels; OR
- The treatment must be for preventing low citrulline levels.

citrulline with carbohydrate containing 1 g citrulline oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5481L NP	4	5	..	*486.55	39.50	Citrulline 1000 [VF]

▪ CYSTINE WITH CARBOHYDRATE

Restricted benefit

Pyridoxine non-responsive homocystinuria

cystine with carbohydrate containing 500 mg cystine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9164H NP	4	5	..	*486.55	39.50	Cystine 500 [VF]

▪ DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE

Restricted benefit

Peroxisomal biogenesis disorders

docosahexaenoic acid with carbohydrate containing 200 mg docosahexaenoic acid oral liquid: powder for, 30 x 4g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10040K NP	4	5	..	*363.31	39.50	docomega [VF]

▪ ESSENTIAL AMINO ACIDS FORMULA

Restricted benefit

Gyrate atrophy of the choroid and retina

Restricted benefit
Urea cycle disorders

essential amino acids formula powder for oral liquid, 2 x 200 g

9329B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*1137.37	39.50	Essential Amino Acid Mix [SB]

▪ ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C

Restricted benefit
Gyrate atrophy of the choroid and retina
Restricted benefit
Urea cycle disorders

essential amino acids formula with minerals and vitamin C powder for oral liquid, 400 g

2027Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	5	..	*598.30	39.50	Dialamine [SB]

▪ ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS

Restricted benefit
Gyrate atrophy of the choroid and retina
Restricted benefit
Urea cycle disorders

essential amino acids formula with vitamins and minerals powder for oral liquid, 50 x 12.5 g sachets

9385Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1436.07	39.50	EAA Supplement [VF]

▪ GLYCINE WITH CARBOHYDRATE

Restricted benefit
Isovaleric acidaemia

glycine with carbohydrate containing 500 mg of glycine oral liquid: powder for, 30 x 4 g sachets

10195N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*511.95	39.50	Glycine500 [VF]

▪ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS

Restricted benefit
Phenylketonuria

glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 81 g

2644E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	14	5	..	*1288.71	39.50	Camino Pro Complete [QH]

glycomacropeptide and essential amino acids with vitamins and minerals oral liquid: powder for, 30 x 49 g sachets

10652P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1570.63	39.50	Camino Pro Bettermilk [QH]

glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 54 g

2696X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	14	5	..	*860.73	39.50	Camino Pro Complete [QH]

▪ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS

Note This product contains higher vitamin A levels than other PBS-listed glycomacropeptide products.

Restricted benefit
Phenylketonuria

glycomacropeptide and essential amino acids with vitamins and minerals containing 10 g protein oral liquid, 30 x 250 mL cartons

10359F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1072.79	39.50	PKU Glytactin RTD 10 [QH]

glycomacropeptide and essential amino acids with vitamins and minerals containing 15 g protein oral liquid, 30 x 250 mL cartons

10332T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1570.59	39.50	PKU Glytactin RTD 15 [QH]

▪ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS

Restricted benefit

Tyrosinaemia

glycomacropeptide and essential amino acids with vitamins and minerals 15 g protein equivalent oral liquid, 30 x 250 mL cartons

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10528D NP	4	5	..	*3101.55	39.50	Tylactin RTD [QH]

▪ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS

Restricted benefit

Phenylketonuria

glycomacropeptide and essential amino acids with vitamins and minerals powder for oral liquid, 30 x 51 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10992M NP	4	5	..	*2068.43	39.50	PKU Bettermilk Lite [QH]

glycomacropeptide and essential amino acids with vitamins and minerals powder for oral liquid, 60 x 20 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11084J NP	5	5	..	*1311.85	39.50	PKU Restore [QH]

▪ GLYCOMACROPEPTIDE FORMULA WITH LONG CHAIN POLYUNSATURATED FATTY ACID AND DOCOSAHEXAENOIC ACID AND LOW PHENYLALANINE

Restricted benefit

Phenylketonuria

glycomacropeptide formula with long chain polyunsaturated fatty acid and docosahexaenoic acid and low phenylalanine powder for oral liquid, 30 x 35 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11071Q NP	4	5	..	*2068.43	39.50	PKU Sphere20 [VF]

glycomacropeptide formula with long chain polyunsaturated fatty acid and docosahexaenoic acid and low phenylalanine powder for oral liquid, 30 x 27 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11245W NP	4	5	..	*1570.63	39.50	PKU Sphere15 [VF]

▪ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE

Note Authorities for increased maximum quantities, up to a maximum of 11, may be authorised.

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

Keyo should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate oral semi-solid, 48 x 100 g tubs

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11108P NP	3	5	..	*866.05	39.50	Keyo [VF]

▪ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE

Note Authorities for increased maximum quantities, up to a maximum of 11, may be authorised.

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

KetoCal 4:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (4:1 ratio long chain fat to carbohydrate plus protein) oral liquid, 32 x 200 mL cartons

10185C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	5	..	*931.85	39.50	KetoCal 4:1 LQ [SB]

▪ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE

Note Authorities for increased maximum quantities, up to a maximum of 48, may be authorised.

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

KetoCal 3:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (3:1 ratio long chain fat to carbohydrate plus protein) powder for oral liquid, 300 g

2652N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	24	5	..	*979.63	39.50	KetoCal 3:1 [SB]

▪ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE

Note Authorities for increased maximum quantities, up to a maximum of 48, may be authorised.

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency.

KetoCal 4:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (4:1 ratio long chain fat to carbohydate plus protein) powder for oral liquid, 300 g

9446E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	24	5	..	*979.63	39.50	KetoCal 4:1 [SB]

▪ ISOLEUCINE WITH CARBOHYDRATE

Restricted benefit

Maple syrup urine disease

isoleucine with carbohydrate containing 50 mg isoleucine oral liquid: powder for, 30 x 4 g sachets

9134R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*486.55	39.50	Isoleucine 50 [VF]

isoleucine with carbohydrate containing 1 g isoleucine oral liquid: powder for, 30 x 4 g sachets

9436P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*534.75	39.50	Isoleucine 1000 [VF]

▪ MILK PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency; OR
- Patient must be an infant or young child with glucose-galactose intolerance and multiple monosaccharide intolerance.

milk protein and fat formula with vitamins and minerals carbohydrate free powder for oral liquid, 225 g

8630F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	24	5	..	*611.71	39.50	Carbohydrate Free Mixture [SB]

▪ PHENYLALANINE WITH CARBOHYDRATE

Restricted benefit

Tyrosinaemia

phenylalanine with carbohydrate containing 50 mg phenylalanine oral liquid: powder for, 30 x 4 g sachets

9384X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*486.55	39.50	Phenylalanine 50 [VF]

▪ PROTEIN FORMULA WITH AMINO ACIDS, CARBOHYDRATES, VITAMINS AND MINERALS WITHOUT PHENYLALANINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit

Phenylketonuria

protein formula with amino acids, carbohydrates, vitamins and minerals without phenylalanine, and supplemented with docosahexaenoic acid oral liquid, 30 x 130 mL pouches

10658Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	5	5	..	*1904.80	39.50	PKU Easy [OH]

▪ SOY PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE

Restricted benefit

Ketogenic diet

Clinical criteria:

- Patient must have intractable seizures requiring treatment with a ketogenic diet; OR
- Patient must have a glucose transport protein defect; OR
- Patient must have pyruvate dehydrogenase deficiency; OR
- Patient must be an infant or young child with glucose-galactose intolerance and multiple monosaccharide intolerance.

soy protein and fat formula with vitamins and minerals carbohydrate free oral liquid, 384 mL can

8577K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	120	5	..	*632.35	39.50	RCF [AB]

▪ TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER

Restricted benefit

Proven inborn errors of protein metabolism

Clinical criteria:

- Patient must be unable to meet their energy requirements with permitted food and formulae.

triglycerides long chain with glucose polymer oral liquid, 6 x 1 L bottles

9309Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*279.67	39.50	ProZero [VF]

triglycerides long chain with glucose polymer oral liquid, 27 x 200 mL cartons

10189G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	5	..	*171.23	39.50	Sno-Pro [SB]

triglycerides long chain with glucose polymer oral liquid, 18 x 250 mL cans

9308X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*314.83	39.50	ProZero [VF]

▪ TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH GLUCOSE POLYMER

Restricted benefit

Proven inborn errors of protein metabolism

Clinical criteria:

- Patient must be unable to meet their energy requirements with permitted food and formulae.

triglycerides medium chain and long chain with glucose polymer powder for oral liquid, 400 g

3136C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	8	5	..	*271.31	39.50	Duocal [SB]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

Authority required (STREAMLINED)

6165

Chylous ascites

Authority required (STREAMLINED)

6192

Chylothorax

Authority required (STREAMLINED)

6173

Fat malabsorption

Clinical criteria:

- The condition must be due to liver disease; OR
- The condition must be due to short gut syndrome; OR
- The condition must be due to cystic fibrosis; OR
- The condition must be due to gastrointestinal disorders.

Authority required (STREAMLINED)

6156

Hyperlipoproteinaemia type 1

Authority required (STREAMLINED)

6136

Long chain fatty acid oxidation disorders

triglycerides medium chain formula powder for oral liquid, 30 x 16 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9383W NP	4	5	..	*230.19	39.50	MCT Pro-Cal [VF]

▪ TYROSINE WITH CARBOHYDRATE

Restricted benefit

Phenylketonuria

tyrosine with carbohydrate containing 1 g tyrosine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9165J NP	4	5	..	*486.55	39.50	Tyrosine 1000 [VF]

▪ VALINE WITH CARBOHYDRATE

Restricted benefit

Maple syrup urine disease

valine with carbohydrate containing 50 mg valine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9135T NP	4	5	..	*486.55	39.50	Valine 50 [VF]

valine with carbohydrate containing 1 g valine oral liquid: powder for, 30 x 4 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9434M NP	4	5	..	*534.75	39.50	Valine 1000 [VF]

▪ VITAMINS, MINERALS AND TRACE ELEMENTS FORMULA

Note Phlexy-Vits must only be used under strict supervision of a dietician and a paediatrician.

Restricted benefit

Dietary management of conditions requiring a highly restrictive therapeutic diet

Clinical criteria:

- Patient must have insufficient vitamin and mineral intake due to a specific diagnosis requiring a highly restrictive therapeutic diet, **AND**
- Patient must be unable to adequately meet vitamin, mineral and trace element needs with other proprietary vitamin and mineral preparations.

Population criteria:

- Patient must be aged 3 years or older.

vitamins, minerals and trace elements formula powder for oral liquid, 30 x 7 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11200L NP	1	5	..	274.69	39.50	Phlexy-Vits [SB]

▪ VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE

Note FruitiVits must only be used under strict supervision of a dietitian and a paediatrician.

Restricted benefit

Dietary management of conditions requiring a highly restrictive therapeutic diet

Clinical criteria:

- Patient must have insufficient vitamin and mineral intake due to a specific diagnosis requiring a highly restrictive therapeutic diet, **AND**
- Patient must be unable to adequately meet vitamin, mineral and trace element needs with other proprietary vitamin and mineral preparations.

Population criteria:

- Patient must be aged 3 years or older.

vitamins, minerals and trace elements with carbohydrate powder for oral liquid, 30 x 6 g sachets

10149E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	5	..	274.69	39.50	FruitiVits [VF]

▪ VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE

Note Paediatric Seravit must only be used under strict supervision of a dietitian and a paediatrician.

Restricted benefit

Dietary management of conditions requiring a highly restrictive therapeutic diet

Clinical criteria:

- Patient must have insufficient vitamin and mineral intake due to a specific diagnosis requiring a highly restrictive therapeutic diet, **AND**
- Patient must be unable to adequately meet vitamin, mineral and trace element needs with other proprietary vitamin and mineral preparations.

Population criteria:

- Patient must be an infant or a child.

vitamins, minerals and trace elements with carbohydrate powder for oral liquid, 200 g

9328Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	6	5	..	*364.57	39.50	Paediatric Seravit [SB]

▪ WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, LONG CHAIN POLYUNSATURATED FATTY ACIDS, VITAMINS AND MINERALS, LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE

Authority required (STREAMLINED)

6190

Chronic renal failure

Population criteria:

- Patient must be an infant or a young child.

Clinical criteria:

- Patient must require treatment with a low protein and a low phosphorus diet; OR
- Patient must require treatment with a low protein, low phosphorus and low potassium diet.

whey protein formula supplemented with amino acids, long chain polyunsaturated fatty acids, vitamins and minerals, low in protein, phosphate, potassium and lactose powder for oral liquid, 10 x 100 g sachets

9382T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	9	5	..	*1406.92	39.50	RenaStart [VF]

whey protein formula supplemented with amino acids, long chain polyunsaturated fatty acids, vitamins and minerals, low in protein, phosphate, potassium and lactose oral liquid: powder for, 6 x 400 g cans

2870C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	5	..	*1500.15	39.50	Renastart [VF]

▪ WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, VITAMINS AND MINERALS, AND LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE

Authority required (STREAMLINED)

6190

Chronic renal failure

Population criteria:

- Patient must be an infant or a young child.

Clinical criteria:

- Patient must require treatment with a low protein and a low phosphorus diet; OR
- Patient must require treatment with a low protein, low phosphorus and low potassium diet.

whey protein formula supplemented with amino acids, vitamins and minerals, and low in protein, phosphate, potassium and lactose powder for oral liquid, 400 g

8587Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	16	5	..	*1007.95	39.50	Kindergen [SB]

Palliative Care

ALIMENTARY TRACT AND METABOLISM....749

STOMATOLOGICAL PREPARATIONS 749
STOMATOLOGICAL PREPARATIONS.... 749
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS.... 749
BELLADONNA AND DERIVATIVES, PLAIN 749
PROPULSIVES.... 749
DRUGS FOR CONSTIPATION 749
DRUGS FOR CONSTIPATION.... 749

MUSCULO-SKELETAL SYSTEM....751

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS.... 751
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS.... 751

NERVOUS SYSTEM....753

ANALGESICS.... 753
OPIOIDS 753
OTHER ANALGESICS AND ANTIPYRETICS.... 758
ANTIEPILEPTICS.... 758
ANTIEPILEPTICS 758
PSYCHOLEPTICS.... 759
ANXIOLYTICS 759
HYPNOTICS AND SEDATIVES 759

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Other agents for local oral treatment

BENZYDAMINE

Authority required (STREAMLINED)

6197

Painful mouth

Clinical criteria:

- Patient must be receiving palliative care.

benzydamine hydrochloride 0.15% mouthwash, 500 mL

5385K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	3	..	24.18	25.39	Difflam [IA]

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, semisynthetic, quaternary ammonium compounds

HYOSCINE BUTYLBROMIDE

Authority required (STREAMLINED)

6207

For use in patients receiving palliative care

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

5317W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	6	3	..	*85.15	39.50	[a] Buscopan [VZ]	[a] HYOSCINE BUTYLBROMIDE SXP [XC]

PROPULSIVES

Propulsives

METOCLOPRAMIDE

Authority required (STREAMLINED)

6084

Nausea or gastric stasis

Clinical criteria:

- Patient must be receiving palliative care.

metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules

10762K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	..	..	*33.95	35.16	Maxolon [IA]

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Contact laxatives

BISACODYL

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

bisacodyl 10 mg suppository, 12

5304E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	3	..	*21.43	22.64	Petrus Bisacodyl Suppositories [PP]

bisacodyl 5 mg enteric tablet, 200

5301B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	17.08	18.29	Lax-Tab [AE]

bisacodyl 10 mg suppository, 10

5303D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	3	3	..	*23.71	24.92	[a] Petrus Bisacodyl Suppositories [PP]
			[B]1.29	*25.00	24.92	[a] Dulcolax [VZ]

Bulk-forming laxatives

▪ RHAMNUS FRANGULA + STERCULIA

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g

5322D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	‡1	3	..	27.57	28.78	Normacol Plus [NE]

Osmotically acting laxatives

▪ MACROGOL-3350

Note Pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 510 g and pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

6170

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets

2351R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*26.23	27.44	[a] Herron ClearLax [ON]

macrogol-3350 1 g/g powder for oral liquid, 510 g

5426N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*26.23	27.44	[a] OsmoLax [KY]

▪ MACROGOL-3350 + SODIUM CHLORIDE + BICARBONATE + POTASSIUM CHLORIDE

Authority required (STREAMLINED)

6171

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

macrogol-3350 13.12 g + sodium chloride 350.7 mg + potassium chloride 46.6 mg (0.63 mmol potassium) + sodium bicarbonate 178.5 mg solution, 30 sachets

5389P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*26.23	27.44	[a] APO-MACROGOL plus ELECTROLYTES [TX] [a] LaxaCon [EA] [a] Macrovic [RF] [a] Movicol [NE]	[a] Chemists' Own Macrogol with Electrolytes [RW] [a] lax-sachets [AE] [a] Molaxole [HM]

macrogol-3350 13.12 g/25 mL + sodium chloride 350.7 mg/25 mL + potassium chloride 46.6 mg/25 mL (0.63 mmol/25 mL potassium) + sodium bicarbonate 178.5 mg/25 mL oral liquid, 500 mL

10127B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*21.17	22.38	Movicol Liquid [NE]

Enemas

▪ BISACODYL

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

bisacodyl 10 mg/5 mL enema, 25 x 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5302C NP	‡1	3	..	38.50	39.50	Bisalax [AS]

▪ SORBITOL + CITRIC ACID + LAURYL SULFOACETATE SODIUM

Restricted benefit

Constipation

Clinical criteria:

- Patient must be receiving palliative care.

sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 12 x 5 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5331N NP	2	3	..	*29.35	30.56	Micolette [AE]

Peripheral opioid receptor antagonists

▪ METHYLNALTREXONE

Authority required (STREAMLINED)

6180

Opioid-induced constipation

Clinical criteria:

- The treatment must be in combination with oral laxatives, **AND**
- Patient must be receiving palliative care, **AND**
- Patient must have failed to respond to laxatives.

methylnaltrexone bromide 12 mg/0.6 mL injection, 0.6 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5423K NP	7	..	..	*263.77	39.50	Relistor [LM]

METHYLNALTREXONE Solution for injection containing methylnaltrexone bromide 12 mg in 0.6 mL, 7

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5424L NP	1	..	..	263.80	39.50	Relistor [LM]

▪ MUSCULO-SKELETAL SYSTEM

▪ ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS

Acetic acid derivatives and related substances

▪ DICLOFENAC

Restricted benefit

Severe pain

Clinical criteria:

- Patient must be receiving palliative care.

diclofenac sodium 100 mg suppository, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5363G NP	2	3	..	*27.51	28.72	Voltaren 100 [NV]

diclofenac sodium 50 mg enteric tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5362F NP	1	3	..	13.14	14.35	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ] [a] Pharmacor Diclofenac 50 [CR]	[a] Clonac 50 [RW] [a] Diclofenac AN [EA] [a] Fenac [AF]
			[B]3.46	16.60	14.35	[a] Voltaren 50 [NV]	

diclofenac sodium 25 mg enteric tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5361E NP	2	3	..	*14.03	15.24	[a] APO-Diclofenac [TX] [a] Diclofenac Amneal [ED] [a] Diclofenac Sandoz [SZ]	[a] Clonac 25 [RW] [a] Diclofenac AN [EA] [a] Fenac 25 [AF]
			[B]3.44	*17.47	15.24	[a] Voltaren 25 [NV]	

▪ INDOMETACIN

Restricted benefit

Severe pain

Clinical criteria:

- Patient must be receiving palliative care.

indometacin 100 mg suppository, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5378C NP	2	3	..	*25.07	26.28	Indocid [AS]

indometacin 25 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5377B NP	2	3	..	*16.69	17.90	[a] Arthrexin [AF]
			[B]4.04	*20.73	17.90	[a] Indocid [AS]

Propionic acid derivatives

▪ IBUPROFEN

Restricted benefit

Severe pain

Clinical criteria:

- Patient must be receiving palliative care.

ibuprofen 400 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
5368M NP	3	3	..	*16.84	18.05	[a] APO-Ibuprofen 400 [TX]	[a] Brufen [GO]

▪ NAPROXEN

Restricted benefit

Severe pain

Treatment criteria:

- Patient must be undergoing palliative care.

Clinical criteria:

- Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

naproxen 125 mg/5 mL oral liquid, 474 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5397C NP	‡1	3	..	121.27	39.50	Phebra Naproxen Suspension [PL]

▪ NAPROXEN

Restricted benefit

Severe pain

Clinical criteria:

- Patient must be receiving palliative care.

naproxen 1 g modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5348L NP	1	3	..	17.65	18.86	[a] Proxen SR 1000 [IY]
			[B]1.12	18.77	18.86	[a] Naprosyn SR1000 [IX]

naproxen 250 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5345H NP	2	3	..	*18.35	19.56	[a] Inza 250 [AF]
			[B]2.24	*20.59	19.56	[a] Naprosyn [IX]

naproxen 500 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5346J NP	1	3	..	16.46	17.67	[a] Inza 500 [AF]
			[B]1.12	17.58	17.67	[a] Naprosyn [IX]

naproxen 750 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5347K NP	1	3	..	16.01	17.22	[a] Proxen SR 750 [IY]
			[B]1.06	17.07	17.22	[a] Naprosyn SR750 [IX]

▪ NAPROXEN

Note Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

Restricted benefit

Severe pain

Clinical criteria:

- Patient must be receiving palliative care.

naproxen sodium 550 mg tablet, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5353R NP	1	3	..	16.61	17.82	[a] Crysanal [IY]
			[B]1.89	18.50	17.82	[a] Anaprox 550 [IX]

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

MORPHINE

Caution The risk of drug dependence is high.

Note Telephone approvals are limited to 1 month's therapy.

Authority required

Chronic severe disabling pain

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 200 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5391R NP	1	2	..	116.58	39.50	MS Contin [MF]

MORPHINE

Caution The risk of drug dependence is high.

Note Telephone approvals are limited to 1 month's therapy.

Authority required

Severe disabling pain

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 20 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5394X NP	1	2	..	19.43	20.64	Sevredol [MF]

morphine sulfate 10 mg tablet, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5393W NP	1	2	..	18.61	19.82	Sevredol [MF]

Phenylpiperidine derivatives

FENTANYL

Caution The risk of drug dependence is high.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Breakthrough pain

Treatment Phase: Initial treatment for dose titration

Clinical criteria:

- Patient must have cancer, **AND**
- Patient must have pain directly attributable to cancer, **AND**
- Patient must be assessed as receiving adequate management of their persistent pain with opioids, **AND**
- Patient must have previously experienced inadequate pain relief following adequate doses of short acting opioids for the treatment of breakthrough pain; OR
- The treatment must be used as short acting opioids are considered clinically inappropriate; OR
- Patient must have previously experienced adverse effects following the use of short acting opioids for breakthrough pain.

Treatment criteria:

- Patient must be undergoing palliative care.

fentanyl 100 microgram sublingual tablet, 10

10601Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*160.32	39.50	Abstral [FK]

FENTANYL Lozenge 200 micrograms (as citrate), 9

5401G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

fentanyl 600 microgram sublingual tablet, 10

10604D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	87.21	39.50	Abstral [FK]

fentanyl 400 microgram sublingual tablet, 10

10603C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	87.21	39.50	Abstral [FK]

FENTANYL Lozenge 1600 micrograms (as citrate), 9

5406M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

fentanyl 300 microgram sublingual tablet, 10

10606F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	87.21	39.50	Abstral [FK]

FENTANYL Lozenge 600 micrograms (as citrate), 9

5403J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

FENTANYL Lozenge 400 micrograms (as citrate), 9

5402H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

fentanyl 800 microgram sublingual tablet, 10

10612M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	87.21	39.50	Abstral [FK]

FENTANYL Lozenge 1200 micrograms (as citrate), 9

5405L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

fentanyl 200 microgram sublingual tablet, 10

10600X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*160.32	39.50	Abstral [FK]

FENTANYL Lozenge 800 micrograms (as citrate), 9

5404K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	96.35	39.50	Actiq [TB]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Breakthrough pain

Treatment Phase: Initial treatment for dose titration

Clinical criteria:

- Patient must have cancer, **AND**
- Patient must have pain directly attributable to cancer, **AND**
- Patient must be assessed as receiving adequate management of their persistent pain with opioids, **AND**
- Patient must have previously experienced inadequate pain relief following adequate doses of short acting opioids for the treatment of breakthrough pain; OR

- The treatment must be used as short acting opioids are considered clinically inappropriate; OR
- Patient must have previously experienced adverse effects following the use of short acting opioids for breakthrough pain.

Treatment criteria:

- Patient must be undergoing palliative care.

fentanyl 600 microgram orally disintegrating tablet, 4

10722H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*72.60	39.50	Fentora [TB]

fentanyl 200 microgram orally disintegrating tablet, 4

10697B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*72.60	39.50	Fentora [TB]

fentanyl 400 microgram orally disintegrating tablet, 4

10739F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*72.60	39.50	Fentora [TB]

fentanyl 100 microgram orally disintegrating tablet, 4

10729Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*72.60	39.50	Fentora [TB]

fentanyl 800 microgram orally disintegrating tablet, 4

10723J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*72.60	39.50	Fentora [TB]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note For first continuing supply, applications for increased repeats for up to 3 months' supply may be authorised.

Note Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Note Telephone approvals are limited to 1 months' therapy.

Authority required

Breakthrough pain

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have cancer, **AND**
- Patient must have pain directly attributable to cancer, **AND**
- Patient must be assessed as receiving adequate management of their persistent pain with opioids, **AND**
- Patient must have previously experienced inadequate pain relief following adequate doses of short acting opioids for the treatment of breakthrough pain; OR
- The treatment must be used as short acting opioids are considered clinically inappropriate; OR
- Patient must have previously experienced adverse effects following the use of short acting opioids for breakthrough pain.

Treatment criteria:

- Patient must be undergoing palliative care.

FENTANYL Lozenge 200 micrograms (as citrate), 30

5407N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*575.36	39.50	Actiq [TB]

fentanyl 600 microgram sublingual tablet, 30

10613N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*461.84	39.50	Abstral [FK]

fentanyl 300 microgram sublingual tablet, 30

10610K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*461.84	39.50	Abstral [FK]

fentanyl 800 microgram sublingual tablet, 30

10611L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*461.84	39.50	Abstral [FK]

FENTANYL Lozenge 800 micrograms (as citrate), 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5410R NP	2	..	..	*575.36	39.50	Actiq [TB]

fentanyl 200 microgram sublingual tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10607G NP	2	..	..	*461.84	39.50	Abstral [FK]

fentanyl 100 microgram sublingual tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10602B NP	2	..	..	*461.84	39.50	Abstral [FK]

FENTANYL Lozenge 400 micrograms (as citrate), 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5408P NP	2	..	..	*575.36	39.50	Actiq [TB]

fentanyl 400 microgram sublingual tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10608H NP	2	..	..	*461.84	39.50	Abstral [FK]

FENTANYL Lozenge 600 micrograms (as citrate), 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5409Q NP	2	..	..	*575.36	39.50	Actiq [TB]

FENTANYL Lozenge 1600 micrograms (as citrate), 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5412W NP	2	..	..	*575.36	39.50	Actiq [TB]

FENTANYL Lozenge 1200 micrograms (as citrate), 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5411T NP	2	..	..	*575.36	39.50	Actiq [TB]

▪ FENTANYL

Caution The risk of drug dependence is high.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Note For first continuing supply, applications for increased repeats for up to 3 months' supply may be authorised.

Note Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Note Telephone approvals are limited to 1 months' therapy.

Authority required

Breakthrough pain

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have cancer, **AND**
- Patient must have pain directly attributable to cancer, **AND**
- Patient must be assessed as receiving adequate management of their persistent pain with opioids, **AND**
- Patient must have previously experienced inadequate pain relief following adequate doses of short acting opioids for the treatment of breakthrough pain; OR
- The treatment must be used as short acting opioids are considered clinically inappropriate; OR
- Patient must have previously experienced adverse effects following the use of short acting opioids for breakthrough pain.

Treatment criteria:

- Patient must be undergoing palliative care.

fentanyl 200 microgram orally disintegrating tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10698C NP	2	..	..	*431.58	39.50	Fentora [TB]

fentanyl 100 microgram orally disintegrating tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10684H NP	2	..	..	*431.58	39.50	Fentora [TB]

fentanyl 400 microgram orally disintegrating tablet, 28

10737D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*431.58	39.50	Fentora [TB]

fentanyl 600 microgram orally disintegrating tablet, 28

10713W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*431.58	39.50	Fentora [TB]

fentanyl 800 microgram orally disintegrating tablet, 28

10738E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	..	..	*431.58	39.50	Fentora [TB]

Diphenylpropylamine derivatives

▪ METHADONE

Caution The risk of drug dependence is high.

Note Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Note Telephone approvals are limited to 1 month's therapy.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Chronic severe disabling pain

Treatment Phase: Initial treatment, for up to 3 months

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- The condition must be unresponsive to non-opioid analgesics.

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

5399E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	2	..	22.60	23.81	Aspen Methadone Syrup [QA]

▪ METHADONE

Caution The risk of drug dependence is high.

Note Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Note Telephone approvals are limited to 1 month's therapy.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Authority required

Chronic severe disabling pain

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- The condition must be unresponsive to non-opioid analgesics.

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

5400F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	..	..	22.60	23.81	Aspen Methadone Syrup [QA]

Oripavine derivatives

▪ BUPRENORPHINE

Caution The risk of drug dependence is high.

Note Telephone approvals are limited to 1 month's therapy.

Authority required

Chronic severe disabling pain

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- The condition must be unresponsive to non-opioid analgesics.

buprenorphine 15 microgram/hour patch, 2

10953L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*80.56	39.50	Norspan [MF]

buprenorphine 20 microgram/hour patch, 2

10970J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*94.76	39.50	Norspan [MF]

buprenorphine 30 microgram/hour patch, 2

10949G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*121.64	39.50	Norspan [MF]

buprenorphine 10 microgram/hour patch, 2

10948F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*66.38	39.50	Norspan [MF]

buprenorphine 25 microgram/hour patch, 2

10964C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*108.20	39.50	Norspan [MF]

buprenorphine 40 microgram/hour patch, 2

10959T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*148.52	39.50	Norspan [MF]

buprenorphine 5 microgram/hour patch, 2

10957Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	2	..	*43.14	39.50	Norspan [MF]

OTHER ANALGESICS AND ANTIPYRETICS

Anilides

▪ PARACETAMOL

Restricted benefit

Analgesia or fever

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- Patient must be intolerant to alternative therapy.

paracetamol 500 mg suppository, 24

5319Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	4	3	..	*82.07	39.50	Panadol [GC]

▪ PARACETAMOL

Note Pharmaceutical benefits that have the form paracetamol 665 mg tablet: modified release, 96 and pharmaceutical benefits that have the form paracetamol 665 mg tablet: modified release, 192 are equivalent for the purposes of substitution.

Restricted benefit

Analgesia or fever

Clinical criteria:

- Patient must be receiving palliative care, **AND**
- Patient must be intolerant to alternative therapy.

paracetamol 665 mg tablet: modified release, 192

10796F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	18.55	19.76	[a] Osteomol 665 Paracetamol [CR]

paracetamol 665 mg modified release tablet, 96

5343F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*18.55	19.76	[a] APOHEALTH Osteo Relief Paracetamol 665 mg [TX]	[a] Osteomol 665 Paracetamol [CR]

▪ ANTIEPILEPTICS

ANTIEPILEPTICS

Benzodiazepine derivatives

▪ CLONAZEPAM

Note No increase in the maximum number of repeats may be authorised.

Authority required

Myoclonus

Clinical criteria:

- The treatment must be for prophylaxis or prevention of the indication, **AND**
- Patient must be receiving palliative care.

clonazepam 500 microgram tablet, 100

5337X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	16.78	17.99	[a] Paxam 0.5 [AF]
			[B]1.84	18.62	17.99	[a] Rivotril [RO]

clonazepam 2.5 mg/mL oral liquid, 10 mL

5339B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*18.59	19.80	Rivotril [RO]

clonazepam 2 mg tablet, 100

5338Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	1	3	..	21.80	23.01	[a] Paxam 2 [AF]
			[B]2.30	24.10	23.01	[a] Rivotril [RO]

▪ PSYCHOLEPTICS

ANXIOLYTICS

Benzodiazepine derivatives

▪ DIAZEPAM

Note No increase in the maximum number of repeats may be authorised.

Authority required

Anxiety

Clinical criteria:

- Patient must be receiving palliative care.

diazepam 5 mg tablet, 50

5356X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	12.48	13.69	[a] Antenex 5 [AF] [a] Ranzepam [RA]	[a] APO-Diazepam [TX] [a] Valpam 5 [RW]
			[B]2.19	14.67	13.69	[a] Valium [RO]	

diazepam 2 mg tablet, 50

5355W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	12.41	13.62	[a] APO-Diazepam [TX]	[a] Valpam 2 [RW]
			[B]2.99	15.40	13.62	[a] Antenex 2 [AF]	

▪ OXAZEPAM

Note No increase in the maximum number of repeats may be authorised.

Authority required

Anxiety

Clinical criteria:

- Patient must be receiving palliative care.

oxazepam 15 mg tablet, 25

5371Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
NP	2	3	..	*13.93	15.14	[a] Alepam 15 [AF]
			[B]5.32	*19.25	15.14	[a] Serepax [QA]

oxazepam 30 mg tablet, 25

5372R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*13.25	14.46	[a] Alepam 30 [AF] [a] Murelax [RW]	[a] APO-Oxazepam [TX]
			[B]4.66	*17.91	14.46	[a] Serepax [QA]	

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

▪ NITRAZEPAM

Note No increase in the maximum number of repeats may be authorised.

Authority required

Insomnia

Clinical criteria:

- Patient must be receiving palliative care.

nitrazepam 5 mg tablet, 25

5359C NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	3	..	*14.31	15.52	[a] Alodorm [AF]
		[B]2.48	*16.79	15.52	[a] Mogadon [IA]

▪ TEMAZEPAM

Note No increase in the maximum number of repeats may be authorised.

Authority required

Insomnia

Clinical criteria:

- Patient must be receiving palliative care.

temazepam 10 mg tablet, 25

5375X NP

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	3	..	*13.25	14.46	[a] APO-Temazepam [TX] [a] Temtabs [FM]	[a] Temaze [AF]
		[B]6.96	*20.21	14.46	[a] Normison [QA]	

Highly Specialised Drugs Program (Private Hospital)

BLOOD AND BLOOD FORMING ORGANS 763

ANTIHEMORRHAGICS 763
VITAMIN K AND OTHER HEMOSTATICS 763
ANTIANEMIC PREPARATIONS 768
OTHER ANTIANEMIC PREPARATIONS 768

CARDIOVASCULAR SYSTEM 772

ANTIHYPERTENSIVES 772
OTHER ANTIHYPERTENSIVES 772

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 823

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES 823
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES 823
HYPOTHALAMIC HORMONES 825

ANTIINFECTIVES FOR SYSTEMIC USE 829

ANTIBACTERIALS FOR SYSTEMIC USE 829
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS 829
ANTIMYCOBACTERIALS 830
DRUGS FOR TREATMENT OF TUBERCULOSIS 830
ANTIVIRALS FOR SYSTEMIC USE 830
DIRECT ACTING ANTIVIRALS 830

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 835

ANTINEOPLASTIC AGENTS 835
ANTIMETABOLITES 835
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES 837
OTHER ANTINEOPLASTIC AGENTS 838
IMMUNOSTIMULANTS 839
IMMUNOSTIMULANTS 839
IMMUNOSUPPRESSANTS 849
IMMUNOSUPPRESSANTS 849

MUSCULO-SKELETAL SYSTEM 967

MUSCLE RELAXANTS 967
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS 967
DRUGS FOR TREATMENT OF BONE DISEASES 968

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION 968

NERVOUS SYSTEM 969

ANTI-PARKINSON DRUGS 969
DOPAMINERGIC AGENTS 969
PSYCHOLEPTICS 970
ANTIPSYCHOTICS 970

RESPIRATORY SYSTEM 970

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 970
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 970
COUGH AND COLD PREPARATIONS 987
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS 987
OTHER RESPIRATORY SYSTEM PRODUCTS 989
OTHER RESPIRATORY SYSTEM PRODUCTS 989

VARIOUS 993

ALL OTHER THERAPEUTIC PRODUCTS 993
ALL OTHER THERAPEUTIC PRODUCTS 993

HSD (Private)

BLOOD AND BLOOD FORMING ORGANS

ANTIHEMORRHAGICS

VITAMIN K AND OTHER HEMOSTATICS

Other systemic hemostatics

ELTROMBOPAG

Note No applications for increased repeats will be authorised.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 1 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy following the splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy following the splenectomy, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 2 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must not have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy, **AND**
- Patient must be unsuitable for splenectomy due to medical reasons, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

Treatment Phase: First Continuing treatment or Re-initiation of interrupted treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised initial treatment with this drug for this condition, **AND**
- Patient must have demonstrated a sustained platelet response to PBS-subsidised treatment with this drug for this condition under the Initial treatment restriction, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised treatment with this drug,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart; OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the First continuing PBS-subsidised treatment or Re-initiation of interrupted PBS-subsidised treatment must be made in writing and must include:

(1) a completed authority prescription form, and

(2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form , and

(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The platelet count must be no more than one month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

Treatment Phase: Second or subsequent Continuing treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a continuing response to treatment with this drug, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purpose of this restriction, a continuing response to treatment with drug is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with this drug

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

The platelet count must be no more than one month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Authority applications for second and subsequent continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial 1, Initial 2, First Continuing treatment or Re-initiation of interrupted treatment, and Second and Subsequent Continuing treatment - balance of supply

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition, **AND**
- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the First Continuing treatment or Re-initiation of interrupted treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Second and subsequent Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

---

eltrombopag 25 mg tablet, 28

5827Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	1483.55	Revolade [NV]

eltrombopag 50 mg tablet, 28

5828R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	2919.95	Revolade [NV]

▪ ROMIPLOSTIM

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 1 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy following the splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy following the splenectomy, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be requested by telephone. The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 2 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must not have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy, **AND**
- Patient must be unsuitable for splenectomy due to medical reasons, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be requested by telephone. The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

HSD (Private)

Authority required

Severe thrombocytopenia

Treatment Phase: First Continuing treatment or Re-initiation of interrupted treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised initial treatment with this drug for this condition, **AND**
- Patient must have demonstrated a sustained platelet response to PBS-subsidised treatment with this drug for this condition under the Initial treatment restriction, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised treatment with this drug,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

Applications for the First continuing PBS-subsidised treatment or Re-initiation of interrupted PBS-subsidised treatment must be made in writing and must include:

(1) a completed authority prescription form, and

(2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form , and

(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The platelet count must be no more than one month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Second or Subsequent Continuing treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a continuing response to treatment with this drug, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purpose of this restriction, a continuing response to treatment with drug is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with this drug

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

The platelet count must be no more than one month old at the time of application.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

Authority applications for second and subsequent periods of continuing therapy may be made by telephone

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Authority applications for second and subsequent continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial 1, Initial 2, First Continuing treatment or Re-initiation of interrupted treatment, and Second and Subsequent Continuing treatment - balance of supply

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition, **AND**
- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the First Continuing treatment or Re-initiation of interrupted treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Second and subsequent Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No applications for increased repeats will be authorised.

romiplostim 500 microgram injection, 1 vial

9699L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1904.40	Nplate [AN]

romiplostim 250 microgram injection, 1 vial

9697J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	972.93	Nplate [AN]

ANTIANEMIC PREPARATIONS

OTHER ANTIANEMIC PREPARATIONS

Other antianemic preparations

▪ DARBEPOETIN ALFA

Authority required

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

darbepoetin alfa 150 microgram/0.3 mL injection, 0.3 mL syringe

6493R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*3756.43	Aranesp SureClick [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 0.5 mL syringe

6492Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*2536.59	Aranesp SureClick [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6325X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1582.97	Aranesp [AN]

darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6324W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1355.09	Aranesp [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6323T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1105.07	Aranesp [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6365B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3756.43	Aranesp [AN]

darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6322R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*913.59	Aranesp [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6326Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2536.63	Aranesp [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 0.3 mL syringe

6490N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*1582.99	Aranesp SureClick [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 0.5 mL syringe

6488L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*669.79	Aranesp SureClick [AN]

darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6320P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*358.97	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6438W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2068.75	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 0.4 mL syringe

6491P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*2068.75	Aranesp SureClick [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 0.4 mL syringe

6489M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*1105.07	Aranesp SureClick [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6321Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*669.71	Aranesp [AN]

▪ EPOETIN ALFA

Authority required

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin alfa 10 000 units/mL injection, 6 x 1 mL syringes

6207Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1918.93	Eprex 10000 [JC]

epoetin alfa 20 000 units/0.5 mL injection, 6 x 0.5 mL syringes

6434P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3729.35	Eprex 20,000 [JC]

epoetin alfa 6000 units/0.6 mL injection, 6 x 0.6 mL syringes

6303R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1239.53	Eprex 6000 [JC]

epoetin alfa 4000 units/0.4 mL injection, 6 x 0.4 mL syringes

6206P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*846.27	Eprex 4000 [JC]

epoetin alfa 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

6205N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*666.05	Eprex 3000 [JC]

epoetin alfa 2000 units/0.5 mL injection, 6 x 0.5 mL syringes

6204M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*517.75	Eprex 2000 [JC]

epoetin alfa 1000 units/0.5 mL injection, 6 x 0.5 mL syringes

6251B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*283.11	Eprex 1000 [JC]

epoetin alfa 5000 units/0.5 mL injection, 6 x 0.5 mL syringes

6302Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1051.63	Eprex 5000 [JC]

epoetin alfa 40 000 units/mL injection, 1 mL syringe

6339P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1238.45	Eprex 40,000 [JC]

epoetin alfa 8000 units/0.8 mL injection, 6 x 0.8 mL syringes

6305W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1593.67	Eprex 8000 [JC]

▪ EPOETIN BETA

Authority required

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin beta 10 000 units/0.6 mL injection, 6 x 0.6 mL syringes

6485H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1918.93	NeoRecormon [RO]

epoetin beta 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

6481D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*666.05	NeoRecormon [RO]

epoetin beta 6000 units/0.3 mL injection, 6 x 0.3 mL syringes

6484G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1239.53	NeoRecormon [RO]

epoetin beta 2000 units/0.3 mL injection, 6 x 0.3 mL syringes

6480C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*517.75	NeoRecormon [RO]

epoetin beta 5000 units/0.3 mL injection, 6 x 0.3 mL syringes

6483F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1051.65	NeoRecormon [RO]

epoetin beta 4000 units/0.3 mL injection, 6 x 0.3 mL syringes

6482E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*846.27	NeoRecormon [RO]

▪ EPOETIN LAMBDA

Authority required

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin lambda 8000 units/0.8 mL injection, 6 x 0.8 mL syringes

9593X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1512.27	Novicrit [SZ]

epoetin lambda 6000 units/0.6 mL injection, 6 x 0.6 mL syringes

9590R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1176.77	Novicrit [SZ]

epoetin lambda 1000 units/0.5 mL injection, 6 x 0.5 mL syringes

9685R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*268.59	Novicrit [SZ]

epoetin lambda 5000 units/0.5 mL injection, 6 x 0.5 mL syringes

9588P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*996.83	Novicrit [SZ]

epoetin lambda 2000 units/mL injection, 6 x 1 mL syringes

9686T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*490.87	Novicrit [SZ]

epoetin lambda 10 000 units/mL injection, 6 x 1 mL syringes

9595B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1820.43	Novicrit [SZ]

epoetin lambda 4000 units/0.4 mL injection, 6 x 0.4 mL syringes

9688X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*802.11	Novicrit [SZ]

epoetin lambda 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

9687W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*631.37	Novicrit [SZ]

▪ METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA

Authority required

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe

9580F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3207.35	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9578D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1321.71	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9577C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1148.03	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9574X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*371.89	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9575Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*615.07	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9576B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*892.41	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9579E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1875.23	Mircera [RO]

CARDIOVASCULAR SYSTEM

ANTIHYPERTENSIVES

OTHER ANTIHYPERTENSIVES

Antihypertensives for pulmonary arterial hypertension

AMBRISENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease,

AND

- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

ambrisentan 10 mg tablet, 30

9649W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2779.80	Volibris [GK]

ambrisentan 5 mg tablet, 30

9648T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2779.80	Volibris [GK]

▪ BOSENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two

weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.

The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

bosentan 125 mg tablet, 60

6430K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	2342.58	[a] Bosentan APOTEX [TX]	[a] BOSENTAN-DRLA [RZ]
				[a] Bosentan GH [GQ]	[a] Bosentan Mylan [AF]
				[a] Bosentan RBX [RA]	[a] Bosentan Sandoz [SZ]
				[a] BOSLEER [RW]	[a] Tracleer [AT]

▪ BOSENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice. The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Cessation of treatment (all patients)

Clinical criteria:

- Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**
- Patient must have not responded to prior PBS-subsidised therapy with this agent, **AND**
- The treatment must be for the purpose of gradual dose reduction prior to ceasing therapy, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment. Treatment beyond 1 month will not be approved.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

bosentan 62.5 mg tablet, 60

6429J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	2342.58	[a] Bosentan APOTEX [TX]	[a] BOSENTAN-DRLA [RZ]
				[a] Bosentan Mylan [AF]	[a] Bosentan RBX [RA]
				[a] Bosentan Sandoz [SZ]	[a] BOSLEER [RW]
				[a] Tracleer [AT]	

▪ EPOPROSTENOL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and

(4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients) or Initial 2 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

epoprostenol 1.5 mg injection [1 vial] (&) inert substance diluent [2 x 50 mL vials], 1 pack

11082G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	77.70	Flolan [GK]

epoprostenol 500 microgram injection, 1 vial

10111E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	43.76	Veletri [AT]

epoprostenol 1.5 mg injection, 1 vial

10129D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	77.70	Veletri [AT]

epoprostenol 500 microgram injection [1 vial] (&) inert substance diluent [2 x 50 mL vials], 1 pack

11069N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	43.76	Flolan [GK]

▪ ILOPROST

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with this agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III drug-induced PAH, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III drug-induced PAH and a mean right atrial pressure greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III drug-induced PAH with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class IV drug-induced PAH, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or drug-induced PAH and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and

(4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

iloprost 20 microgram/2 mL inhalation solution, 30 x 2 mL ampoules

6456T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	432.39	Ventavis [BN]

▪ MACITENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to

connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

A maximum of 5 repeats will be authorised.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

HSD (Private)

macitentan 10 mg tablet, 30

10134J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2923.62	Opsumit [AT]

▪ RIOCIGUAT

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 1 month following cessation of therapy, as recommended by the TGA-approved Product Information.

Note Special Pricing Arrangements apply.

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have WHO Functional Class II, III or IV CTEPH, **AND**
- The condition must be inoperable by pulmonary endarterectomy; OR
- The condition must be recurrent or persistent following pulmonary endarterectomy, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

CTEPH that is inoperable by pulmonary endarterectomy is defined as follows:

- Right heart catheterisation (RHC) demonstrating pulmonary vascular resistance (PVR) of greater than 300 dyn*sec*cm^{-5} measured at least 90 days after start of full anticoagulation; and
- A mean pulmonary artery pressure (PAPmean) of greater than 25 mmHg at least 90 days after start of full anticoagulation.

CTEPH that is recurrent or persistent subsequent to pulmonary endarterectomy is defined as follows:

- RHC demonstrating a PVR of greater than 300 dyn*sec*cm^{-5} measured at least 180 days following pulmonary endarterectomy.

Where a RHC cannot be performed due to right ventricular dysfunction, an echocardiogram demonstrating the dysfunction must be provided at the time of application.

Applications for authorisation must be in writing and must include:(1) completed authority prescription forms sufficient for dose titration; and(2) a completed CTEPH PBS Initial Authority Application - Supporting Information form which includes results from the 3 tests below, to establish baseline measurements, where available:(i) RHC composite assessment, and(ii) ECHO composite assessment, and(iii) 6 Minute Walk Test (6MWT); and(3) a signed patient acknowledgment form; and(4) confirmation of evidence of inoperable CTEPH including results of a pulmonary vascular resistance (PVR), a mean pulmonary artery pressure (PAPmean) and the starting date of full anticoagulation; or(5) confirmation of evidence of recurrent or persistent CTEPH including result of PVR and the date that pulmonary endarterectomy was performed; or(6) confirmation of an echocardiogram demonstrating right ventricular dysfunction.

Where it is not possible to perform all 3 tests above on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT;(3) RHC composite assessment only.

In circumstance where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) ECHO composite assessment plus 6MWT;(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Prescriptions for dose titration must provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, The quantity approved must be based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 3 repeats.

The assessment of the patient's response to the initial 20-week course of treatment should be made following the preceding 16 weeks of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must demonstrate stable or responding disease, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed CTEPH PBS Continuing Authority Application - Supporting Information form which includes results from the three tests below, where available:(i) RHC composite assessment; and(ii) ECHO composite assessment; and(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to this drug is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease.

The assessment of the patient's response to the continuing 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

The maximum quantity per prescription must be based on the dosage recommendations in the TGA-approved Product Information and be limited to provide sufficient supply for 1 month of treatment.

A maximum of 5 repeats will be authorised.

Applications for continuing treatment with this drug should be made two weeks prior to the completion of the 6-month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate disease stability or improvement to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Grandfathered patients

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 January 2017, **AND**
- Patient must have a documented history of WHO Functional Class II, III or IV CTEPH, **AND**
- The condition must be inoperable by pulmonary endarterectomy; OR
- The condition must be recurrent or persistent following pulmonary endarterectomy.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Clinical criteria:

- The treatment must be the sole PBS-subsidised agent for this condition.

Population criteria:

- Patient must be aged 18 years or older.

CTEPH that is inoperable by pulmonary endarterectomy is defined as follows:

- Right heart catheterisation (RHC) demonstrating pulmonary vascular resistance (PVR) of greater than 300 dyn*sec*cm^{-5} measured at least 90 days after start of full anticoagulation; and
- A mean pulmonary artery pressure (PAPmean) of greater than 25 mmHg at least 90 days after start of full anticoagulation.

CTEPH that is recurrent or persistent subsequent to pulmonary endarterectomy is defined as follows:

- RHC demonstrating a PVR of greater than 300 dyn*sec*cm^{-5} measured at least 180 days following pulmonary endarterectomy.

Where a RHC cannot be performed due to right ventricular dysfunction, an echocardiogram demonstrating the dysfunction must be provided at the time of application.

Applications for authorisation must be in writing and must include:(1) A completed authority prescription form; and(2) a completed CTEPH PBS Initial Authority Application - Supporting Information form which includes results from the 3 tests below, to establish baseline measurements, where available:(i) RHC composite assessment, and(ii) ECHO composite assessment, and(iii) 6 Minute Walk Test (6MWT); and(3) a signed patient acknowledgment form; and(4) confirmation of evidence of inoperable CTEPH including results of a pulmonary vascular resistance (PVR), a mean pulmonary artery pressure (PAPmean) and the starting date of full anticoagulation; or(5) confirmation of evidence of recurrent or persistent CTEPH including result of PVR and the date that pulmonary endarterectomy was performed; or(6) confirmation of an echocardiogram demonstrating right ventricular dysfunction.

Where it is not possible to perform all 3 tests above on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT;(2) RHC composite assessment only.

In circumstance where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) ECHO composite assessment plus 6MWT;(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial treatment restriction to complete a maximum of 20 weeks of treatment; OR
- Patient must have received insufficient therapy with this agent under the Continuing treatment restriction to complete a maximum of 24 weeks of treatment; OR
- Patient must have received insufficient therapy with this agent under the Grandfathering restriction to complete a maximum of 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 20 or 24 weeks of treatment available under the above respective restriction, **AND**
- The treatment must be the sole PBS-subsidised agent for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

riociguat 500 microgram tablet, 42

11009K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 2.5 mg tablet, 84

11018X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 2.5 mg tablet, 42

10985E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 1 mg tablet, 42

10990K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 2 mg tablet, 42

11012N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 500 microgram tablet, 84

11008J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1.5 mg tablet, 84

10975P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1 mg tablet, 84

11010L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 2 mg tablet, 84

11017W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1.5 mg tablet, 42

10974N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

▪ RIOCIGUAT

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 1 month following cessation of therapy, as recommended by the TGA-approved Product Information.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension Initial PBS Authority Application - Supporting Information form which includes results from the three tests below, where available: (i) RHC composite assessment; and (ii) ECHO composite assessment; and (iii) 6 Minute Walk Test (6MWT); and (3) a signed patient acknowledgement. Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows: (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension Initial PBS Authority Application - Supporting Information form which includes results from the three tests below, where available: (i) RHC composite assessment; and (ii) ECHO composite assessment; and (iii) 6 Minute Walk Test (6MWT); and (3) a signed patient acknowledgement. Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows: (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application. The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made two weeks prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 4 (Grandfathered patients)

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must be receiving treatment with this drug at the time of application, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a documented history of a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have a documented history of right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have a documented history of failure to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows: The first written application for PBS-subsidised treatment should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements. The test results provided must not be more than 2 months old at the time of application.Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment: (1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT; (3) RHC composite assessment only. In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the

following test combinations, which are listed in descending order of preference: (1) ECHO composite assessment plus 6MWT; (2) ECHO composite assessment only. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approval for authority prescriptions will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 5 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note No applications for increased repeats will be authorised.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 5 (Grandfathered patients)

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must be receiving treatment with this drug at the time of application, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have a documented history of WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have a documented history of WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have a documented history of WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows: The first written application for PBS-subsidised treatment should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements. The test results provided must not be more than 2 months old at the time of application.Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment: (1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT; (3) RHC composite assessment only. In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference: (1) ECHO composite assessment plus 6MWT; (2) ECHO composite assessment only. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

Approval for authority prescriptions will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 5 repeats.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note No applications for increased repeats will be authorised.

riociguat 500 microgram tablet, 42

11031N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 2.5 mg tablet, 84

11035T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 2.5 mg tablet, 42

11052Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 1 mg tablet, 42

11028K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 2 mg tablet, 42

11045H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

riociguat 500 microgram tablet, 84

11058B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1.5 mg tablet, 84

11061E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1 mg tablet, 84

11060D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 2 mg tablet, 84

11030M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3482.57	Adempas [BN]

riociguat 1.5 mg tablet, 42

11046J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1764.86	Adempas [BN]

▪ SILDENAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and
(ii) ECHO composite assessment; and
(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;
(2) RHC plus ECHO composite assessments;
(3) RHC composite assessment plus 6MWT;
(4) ECHO composite assessment plus 6MWT;
(5) RHC composite assessment only;
(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

sildenafil 20 mg tablet, 90

9605M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	339.66	[a] APO-Sildenafil PHT [TX] [a] Sildenafil AN PHT 20 [EA] [a] Sildenafil Sandoz PHT 20 [SZ]	[a] Revatio [PF] [a] SILDENAFIL-DRx [RZ]

HSD (Private)

▪ TADALAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;
(3) RHC composite assessment plus 6MWT;
(4) ECHO composite assessment plus 6MWT;
(5) RHC composite assessment only;
(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

---

tadalafil 20 mg tablet, 56

1304P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	835.61	Adcirca [LY]

▪ SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

▪ PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

Other anterior pituitary lobe hormones and analogues

▪ PEGVISOMANT

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue.

Somatostatin analogues include octreotide, lanreotide and pasireotide

Failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide is defined as:

1) Growth hormone level greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Two completed authority prescriptions should be submitted with the initial application for this drug. One prescription should be for the loading dose of 80 mg for a quantity of 4 vials of 20 mg with no repeats. The second prescription should be for subsequent doses, starting from 10 mg daily, and allowing dose adjustments in increments of 5 mg based on serum IGF-1 levels measured every 4 to 6 weeks in order to maintain the serum IGF-1 level within the age-adjusted normal range based on the dosage recommendations in the TGA-approved Product Information.

The authority application must be made in writing and must include:

a) two completed authority prescription forms ; and

b) a completed Acromegaly Pegvisomant initial PBS Authority Application - Supporting Information Form; and

c) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and

d) a recent result of the IGF-1 level and the date of assessment ; and

e) demonstration of failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide

No increase in the maximum quantity or number of units may be authorised for the loading dose.

pegvisomant 20 mg injection [1 vial] (&) inert substance diluent [1 syringe], 1 pack

11166Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	..	..	*586.59	Somavert [PF]

▪ PEGVISOMANT

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue.

Somatostatin analogues include octreotide, lanreotide and pasireotide

Failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide is defined as:

1) Growth hormone level greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Two completed authority prescriptions should be submitted with the initial application for this drug. One prescription should be for the loading dose of 80 mg for a quantity of 4 vials of 20 mg with no repeats. The second prescription should be for subsequent doses, starting from 10 mg daily, and allowing dose adjustments in increments of 5 mg based on serum IGF-1 levels measured every 4 to 6 weeks in order to maintain the serum IGF-1 level within the age-adjusted normal range based on the dosage recommendations in the TGA-approved Product Information.

The authority application must be made in writing and must include:

a) two completed authority prescription forms ; and

b) a completed Acromegaly Pegvisomant initial PBS Authority Application - Supporting Information Form; and

c) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and

d) a recent result of the IGF-1 level and the date of assessment ; and

e) demonstration of failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide

No increase in the maximum quantity or number of units may be authorised for the loading dose.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acromegaly

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition., **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue, **AND**
- The treatment must cease if IGF-1 is not lower after 3 months of pegvisomant treatment at the maximum tolerated dose.

Somatostatin analogues include octreotide, lanreotide and pasireotide

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

In a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of IGF-1 level taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided at the time of application.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Acromegaly

Treatment Phase: Grandfathering

Clinical criteria:

- Patient must have received non-PBS subsidised treatment with this drug for this condition prior to 1 September 2017, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue, **AND**
- Patient must have had a documented age- and sex- adjusted insulin- like factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN) prior to commencing non- PBS- subsidised treatment with this drug.

Somatostatin analogues include octreotide, lanreotide and pasireotide

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Treatment must be ceased if IGF-1 level is not lower after 3 months of pegvisomant treatment at the maximum tolerated dose.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be made in writing and must include:

1. a completed authority prescription form; and
2. a completed Acromegaly Pegvisomant Grandfather PBS Authority Application - Supporting Information Form; and
3. in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and
4. a recent result of the IGF-1 level and the date of assessment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pegvisomant 15 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11172B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4225.72	Somavert [PF]

pegvisomant 10 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11167R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4225.72	Somavert [PF]

pegvisomant 20 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11174D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4225.72	Somavert [PF]

HYPOTHALAMIC HORMONES

Somatostatin and analogues

▪ LANREOTIDE

Authority required

Acromegaly

Clinical criteria:

- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (6 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

lanreotide 30 mg modified release injection [1 vial] (&) inert substance diluent [2 mL ampoule], 1 pack

6332G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*1472.15	Somatuline LA [IS]

▪ LANREOTIDE

Authority required

Acromegaly

Clinical criteria:

- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Authority required

Functional carcinoid tumour

Clinical criteria:

- The condition must be causing intractable symptoms, **AND**
- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 120 mg every 28 days.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

lanreotide 120 mg/0.5 mL injection, 0.5 mL syringe

6425E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*4303.15	Somatuline Autogel [IS]

lanreotide 60 mg/0.5 mL injection, 0.5 mL syringe

6423C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*2602.65	Somatuline Autogel [IS]

lanreotide 90 mg/0.5 mL injection, 0.5 mL syringe

6424D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*3448.15	Somatuline Autogel [IS]

▪ OCTREOTIDE

Authority required

Acromegaly

Clinical criteria:

- The condition must be controlled with octreotide immediate release injections, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission

Authority required

Functional carcinoid tumour

Clinical criteria:

- Patient must have achieved symptom control on octreotide immediate release injections, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

Authority required

Vasoactive intestinal peptide secreting tumour (VIPoma)

Clinical criteria:

- Patient must have achieved symptom control on octreotide immediate release injections, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 20 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10549F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*3526.77	Sandostatin LAR [NV]

octreotide 30 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10558Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*4402.07	Sandostatin LAR [NV]

octreotide 10 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10566D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*2660.87	Sandostatin LAR [NV]

▪ OCTREOTIDE

Authority required

Acromegaly

Clinical criteria:

- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks, **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment at a dose of 100 micrograms 3 time daily, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission

Authority required

Functional carcinoid tumour

Clinical criteria:

- The condition must be causing intractable symptoms, **AND**
- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

Authority required

Vasoactive intestinal peptide secreting tumour (VIPoma)

Clinical criteria:

- The condition must be causing intractable symptoms, **AND**
- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 50 microgram/mL injection, 5 x 1 mL ampoules

6227R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
18	11	..	*651.01	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.05 [NV]

octreotide 500 microgram/mL injection, 5 x 1 mL ampoules

6229W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*6241.63	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.5 [NV]

octreotide 100 microgram/mL injection, 5 x 1 mL ampoules

6228T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*1283.53	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.1 [NV]

▪ PASIREOTIDE

Caution Careful monitoring of patients is mandatory due to high risk of developing hyperglycaemia

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have a mean growth hormone (GH) level greater than 2.5 micrograms per litre, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) level greater than 1.3 times the upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

Population criteria:

- Patient must be aged 18 years or older.

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

Failure to achieve biochemical control is defined as:

1) Growth hormone level is greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as:

1) Growth hormone (GH) levels of less than 2.5 mcg/L; and

2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)

The authority application must be made in writing and must include:

a) a completed authority prescription form; and

b) a completed Acromegaly PBS Authority Application - Supporting Information Form; and

c) a signed patient acknowledgment; and

d) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided; and

e) a recent copy of GH and IGF-1 levels must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acromegaly

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have received non-PBS treatment with this drug for this condition prior to 1 September 2016.

Population criteria:

- Patient must be aged 18 years or older.

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as:
1) Growth hormone (GH) levels of less than 2.5 mcg/L; and
2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)
The authority application must be made in writing and must include:
a) a completed authority prescription form; and
b) a completed Acromegaly PBS Authority Application - Supporting Information Form; and
c) a signed patient acknowledgment; and
d) in a patient who has previously been treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required
Acromegaly
Treatment Phase: Continuing treatment
Clinical criteria:
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

Population criteria:
- Patient must be aged 18 years or older.

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.
Biochemical evidence of remission is defined as:
1) Growth hormone (GH) levels of less than 2.5 mcg/L; and
2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)
In a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy and the GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided at the time of approval.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pasireotide 40 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10884W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*7847.15	Signifor LAR [NV]

pasireotide 60 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10887B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*7847.15	Signifor LAR [NV]

pasireotide 20 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10880P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*7847.15	Signifor LAR [NV]

▪ ANTIINFECTIVES FOR SYSTEMIC USE

▪ ANTIBACTERIALS FOR SYSTEMIC USE

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

▪ AZITHROMYCIN

Authority required
Mycobacterium avium complex infection
Clinical criteria:
- The treatment must be for prophylaxis, **AND**

- Patient must be human immunodeficiency virus (HIV) positive, **AND**
- Patient must have CD4 cell counts of less than 75 per cubic millimetre.

azithromycin 600 mg tablet, 8

6221K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*122.35	Zithromax [PF]

▪ CLARITHROMYCIN

Authority required

Mycobacterium avium complex infection

clarithromycin 500 mg tablet, 100

6152T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	41.61	APO-Clarithromycin [TX]

▪ ANTIMYCOBACTERIALS

DRUGS FOR TREATMENT OF TUBERCULOSIS

Antibiotics

▪ RIFABUTIN

Authority required

Mycobacterium avium complex infection

Clinical criteria:

- Patient must be human immunodeficiency virus (HIV) positive.

Authority required

Mycobacterium avium complex infection

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be human immunodeficiency virus (HIV) positive, **AND**
- Patient must have CD4 cell counts of less than 75 per cubic millimetre.

rifabutin 150 mg capsule, 30

6195C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	5	..	*646.75	Mycobutin [PF]

▪ ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

▪ GANCICLOVIR

Authority required

Cytomegalovirus disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a bone marrow transplant recipient at risk of cytomegalovirus disease.

Authority required

Cytomegalovirus disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a solid organ transplant recipient at risk of cytomegalovirus disease.

ganciclovir 500 mg injection, 5 vials

6136Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	1	..	*560.43	Cymevene [RO]

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**

- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10675W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	225.55	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10923X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	81.15	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10623D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	152.75	Ibavyr [IX]

HSD (Private)

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10637W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	225.55	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10938Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	81.15	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10635R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	152.75	Ibavyr [IX]

▪ VALACICLOVIR

Authority required

Cytomegalovirus infection and disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must have undergone a renal transplant, **AND**
- Patient must be at risk of cytomegalovirus disease.

valaciclovir 500 mg tablet, 100

6280M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	2	..	*237.00	[a] APO-Valaciclovir [TX]	[a] Valaciclovir RBX [RA]
			[B]2.30	*239.30	[a] Valtrex [RW]	

▪ VALGANCICLOVIR

Authority required

Cytomegalovirus infection and disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a solid organ transplant recipient at risk of cytomegalovirus disease.

valganciclovir 50 mg/mL powder for oral liquid, 100 mL

9675F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	11	5	..	*#4396.02	Valcyte [RO]

valganciclovir 450 mg tablet, 60

6357N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*3631.45	[a] Valcyte [RO] [a] Valganciclovir Juno [JU] [a] Valganciclovir Sandoz [SZ]	[a] Valganciclovir AN [EA] [a] Valganciclovir Mylan [AF]

Other antivirals

▪ DACLATASVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

daclatasvir 30 mg tablet, 28

10630L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	7713.82	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

10631M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	7713.82	Daklinza [BQ]

▪ DACLATASVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

daclatasvir 30 mg tablet, 28

10643E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	7713.82	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

10644F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	7713.82	Daklinza [BQ]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10979W	1	2	..	21047.15	Zepatier [MK]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 16 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10991L	1	3	..	21047.15	Zepatier [MK]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 8 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10653Q	1	1	..	22113.82	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10672Q	1	2	..	22113.82	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

10679C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	22113.82	Harvoni [GI]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:
- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56], 4 x 28

10749R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	13900.28	Viekira Pak [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:
- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:
- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

10750T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	13900.28	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

10753Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	13900.28	Viekira Pak-RBV [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:
- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:
- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

10773B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	13900.28	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

10761J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	13900.28	Viekira Pak-RBV [VE]

▪ SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg tablet, 28

10654R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	19344.90	Sovaldi [GI]

▪ SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

sofosbuvir 400 mg tablet, 28

10676X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	19344.90	Sovaldi [GI]

▪ SOFOSBUVIR + VELPATASVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg + velpatasvir 100 mg tablet, 28

11144M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	22113.82	Epclusa [GI]

▪ ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

▪ ANTINEOPLASTIC AGENTS

ANTIMETABOLITES

Pyrimidine analogues

▪ AZACITIDINE

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be classified as Intermediate-2 according to the International Prognostic Scoring System (IPSS); OR
- The condition must be classified as high risk according to the International Prognostic Scoring System (IPSS).

Classification of the condition as Intermediate-2 requires a score of 1.5 to 2.0 on the IPSS, achieved with the possible combinations:

a. 11% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 0 to 1 cytopenias; OR

b. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 0 to 1 cytopenias; OR

c. 11% to 20% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR

d. 5% to 10% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

e. 5% to 10% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias; OR

f. Less than 5% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), and 2 to 3 cytopenias.

Classification of the condition as high risk requires a score of 2.5 or more on the IPSS, achieved with the possible combinations:

a. 21% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR

b. 21% to 30% marrow blasts with intermediate (other abnormalities) or poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

c. 11% to 20% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

d. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias.

The first authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and

(d) a copy of the full blood examination report; and

(e) a copy of the pathology report detailing the cytogenetics demonstrating intermediate-2 or high risk disease according to the International Prognostic Scoring System (IPSS); and

(f) a signed patient acknowledgment form.

No more than 3 cycles will be authorised.

Authority required

Chronic Myelomonocytic Leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must have 10% to 29% marrow blasts without Myeloproliferative Disorder.

The first authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has chronic myelomonocytic leukaemia ; and

(d) a copy of the full blood examination report; and

(e) a signed patient acknowledgement.

No more than 3 cycles will be authorised.

Authority required

Acute Myeloid Leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must have 20% to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification.

The first authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has acute myeloid leukaemia; and
(d) a copy of the full blood examination report; and
(e) a signed patient acknowledgement.
No more than 3 cycles will be authorised.

azacitidine 100 mg injection, 1 vial

6100C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
14	2	..	*5219.35	[a] Azacitidine Accord [OC] [a] Azadine [RZ] [a] Vidaza [CJ]	[a] AZACITIDINE DR.REDDY'S [RI] [a] Celazadine [JU]

▪ AZACITIDINE

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

HSD (Private)

Authority required
Myelodysplastic syndrome
Treatment Phase: Continuing treatment
Clinical criteria:
- The condition must be classified as Intermediate-2 according to the International Prognostic Scoring System (IPSS); OR
- The condition must be classified as high risk according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

Authority required
Chronic Myelomonocytic Leukaemia
Treatment Phase: Continuing treatment
Clinical criteria:
- The condition must have 10% to 29% marrow blasts without Myeloproliferative Disorder, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

Authority required
Acute Myeloid Leukaemia
Treatment Phase: Continuing treatment
Clinical criteria:
- The condition must have 20% to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

azacitidine 100 mg injection, 1 vial

6138C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
14	5	..	*5219.35	[a] Azacitidine Accord [OC] [a] Azadine [RZ] [a] Vidaza [CJ]	[a] AZACITIDINE DR.REDDY'S [RI] [a] Celazadine [JU]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

▪ DOXORUBICIN HYDROCHLORIDE-PEGYLATED LIPOSOMAL

Authority required
Kaposi sarcoma
Clinical criteria:
- The condition must be AIDS-related, **AND**
- Patient must have a CD4 cell count of less than 200 per cubic millimetre, **AND**
- The condition must include extensive mucocutaneous involvement.

Authority required
Kaposi sarcoma
Clinical criteria:
- The condition must be AIDS-related, **AND**
- Patient must have a CD4 cell count of less than 200 per cubic millimetre, **AND**
- The condition must include extensive visceral involvement.

doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial

6249X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*1106.35	[a] Caelyx [JC]	[a] Liposomal Doxorubicin SUN [RA]

OTHER ANTINEOPLASTIC AGENTS

Monoclonal antibodies

▪ RITUXIMAB

Note Risk of end-organ damage or mortality includes a minimum of one of the following:Glomerulonephritis with risk of progression
- Risk to sight including scleritis/episcleritis, sudden visual loss, uveitis, retinal changes (vasculitis/thrombosis/exudates/haemorrhage)
- Bronchial/subglottic obstruction
- Pulmonary haemorrhage
- Parenchymal lung disease
- Sensory neural hearing loss
- Recurrent sinonasal disease requiring recurrent surgical interventions
- Meningitis, organic confusion, seizures, stroke, cord lesion, cranial nerve palsy, sensory peripheral neuropathy, motor mononeuritis multiplex

Note Patients could be considered contraindicated, refractory, or unable to tolerate cyclophosphamide for one of the following reasons: Cyclophosphamide is contraindicated as per the TGA approved Product Information;
- Cyclophosphamide is not recommended due to the need to preserve gonad function;
- Patient experiences severe toxicity to cyclophosphamide that warrants cessation of treatment;
- Patient has life- or organ-threatening deterioration at any time during treatment with cyclophosphamide, where the deterioration is thought to be due to severe uncontrolled active vasculitis;
- Commencing a further treatment cycle with cyclophosphamide would exceed the maximum cumulative dose of cyclophosphamide of 25g; or
- Patient's condition with this indication is persistent despite at least 3 months therapy with cyclophosphamide.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment.

Authority required

Severe active granulomatosis with polyangiitis (Wegeners granulomatosis)

Treatment Phase: Induction of remission

Clinical criteria:
- The treatment must be for the induction of remission, **AND**
- Patient must not have previously received this drug for this condition; OR
- Patient must have received this drug for this condition prior to 1 January 2016, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance of remission

The authority application must be made in writing

Authority required

Severe active microscopic polyangiitis

Treatment Phase: Induction of remission

Clinical criteria:
- The treatment must be for the induction of remission, **AND**
- Patient must not have previously received this drug for this condition; OR
- Patient must have received this drug for this condition prior to 1 January 2016, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance therapy.
The authority application must be made in writing

Authority required

Severe active granulomatosis with polyangiitis (Wegeners granulomatosis)
Treatment Phase: Re-induction of remission

Clinical criteria:

- The treatment must be for the re-induction of remission, **AND**
- Patient must have previously received and responded to this drug for this condition, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.
This drug is not PBS-subsidised for maintenance of remission
The authority application must be made in writing

Authority required

Severe active microscopic polyangiitis
Treatment Phase: Re-induction of remission

Clinical criteria:

- The treatment must be for the re-induction of remission, **AND**
- Patient must have previously received and responded to this drug for this condition, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.
This drug is not PBS-subsidised for maintenance therapy.
The authority application must be made in writing

rituximab 100 mg/10 mL injection, 2 x 10 mL vials

10583B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	767.17	Mabthera [RO]

rituximab 500 mg/50 mL injection, 50 mL vial

10576P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1874.09	Mabthera [RO]

▪ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Colony stimulating factors

▪ FILGRASTIM

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**

- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

Authority required

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be to facilitate harvest of peripheral blood progenitor cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy.

Authority required

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be in a normal volunteer for use in allogeneic transplantation.

Authority required

Assisting bone marrow transplantation

Clinical criteria:

- Patient must be receiving marrow-ablative chemotherapy prior to the transplantation.

Authority required

Assisting autologous peripheral blood progenitor cell transplantation

Clinical criteria:

- The treatment must be following marrow-ablative chemotherapy for non-myeloid malignancy prior to the transplantation.

Authority required

Severe congenital neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 100 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, **AND**
- Patient must have had a bone marrow examination that has shown evidence of maturational arrest of the neutrophil lineage.

Authority required

Severe chronic neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 1,000 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart; OR
- Patient must have neutrophil dysfunction, **AND**
- Patient must have experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics in the previous 12 months; OR
- Patient must have had at least 3 recurrent clinically significant infections in the previous 12 months.

Authority required

Chronic cyclical neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 500 million cells per litre lasting for 3 days per cycle, measured over 3 separate cycles, **AND**
- Patient must have experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics; OR
- Patient must have had at least 3 recurrent clinically significant infections in the previous 12 months.

filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2747N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
4	11	..	*958.07	Zarzio [SZ]

filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes

5830W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*387.51	Nivestim [PF]

filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes

1113N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*1512.93	TevaGrastim [TB]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

6292E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1512.93	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9695G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1512.93	Nivestim [PF]

filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials

6127L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1512.93	Neupogen [AN]

filgrastim 300 microgram/mL injection, 10 x 1 mL vials

6126K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*958.09	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2733W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	11	..	*1512.91	Zarzio [SZ]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

1082Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*958.09	TevaGrastim [TB]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

6291D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*958.09	Neupogen [AN]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9693E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*958.09	Nivestim [PF]

▪ LENOGRASTIM

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Ewing's sarcoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin's lymphoma (intermediate or high grade).

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in osteosarcoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in rhabdomyosarcoma.

Authority required

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be to facilitate harvest of peripheral blood progenitor cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy.

Authority required

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be in a normal volunteer for use in allogeneic transplantation.

Authority required

Assisting peripheral blood progenitor cell or bone marrow transplantation

Clinical criteria:

- The treatment must be following marrow-ablative chemotherapy for non-myeloid malignancy prior to the transplantation.

LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10

6337M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*1019.87	Granocyte 13 [PF]

LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10

6338N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*2485.99	Granocyte 34 [PF]

▪ LIPEGFILGRASTIM

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

lipegfilgrastim 6 mg/0.6 mL injection, 0.6 mL syringe

10931H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	11	..	1297.15	Lonquex [TB]

HSD (Private)

▪ PEGFILGRASTIM

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR

- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

pegfilgrastim 6 mg/0.6 mL injection, 0.6 mL syringe

6363X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	1297.15	[a] Neulasta [AN]	[a] Ristempa [GV]

Interferons

▪ INTERFERON ALFA-2A

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Chronic Myeloid Leukaemia (CML)

Clinical criteria:

- The condition must be Philadelphia chromosome positive.

interferon alfa-2a 3 million units/0.5 mL injection, 0.5 mL syringe

6210W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	30	5	..	*890.35	Roferon-A [RO]

interferon alfa-2a 9 million units/0.5 mL injection, 0.5 mL syringe

6213B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	30	5	..	*2594.35	Roferon-A [RO]

▪ INTERFERON ALFA-2B

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Chronic Myeloid Leukaemia (CML)

Clinical criteria:

- The condition must be Philadelphia chromosome positive.

Authority required

Malignant melanoma

Clinical criteria:

- The treatment must be as adjunctive therapy to current standard care, **AND**
- Patient must have undergone surgery, **AND**
- The condition must include nodal involvement.

interferon alfa-2b 30 million units/1.2 mL injection, 1.2 mL

6254E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*595.81	Intron A Redipen [MK]

interferon alfa-2b 10 million units/mL injection, 5 x 1 mL vials

6246R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	3	5	..	*1462.18	Intron A [MK]

interferon alfa-2b 18 million units/3 mL injection, 3 mL vial

6218G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	15	5	..	*2594.20	Intron A [MK]

interferon alfa-2b 60 million units/1.2 mL injection, 1.2 mL

6255F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1179.17	Intron A Redipen [MK]

interferon alfa-2b 25 million units/2.5 mL injection, 2.5 mL vial

6219H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	15	5	..	*3584.80	Intron A [MK]

interferon alfa-2b 18 million units/1.2 mL injection, 1.2 mL

6253D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*360.33	Intron A Redipen [MK]

▪ INTERFERON GAMMA-1B

Authority required

Chronic granulomatous disease

Clinical criteria:

- Patient must have frequent and severe infections despite adequate prophylaxis with antimicrobial agents.

interferon gamma-1b 2 million units (100 microgram)/0.5 mL injection, 6 x 0.5 mL vials

6148N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*2632.87	Imukin [BY]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Note Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:
(a) a nurse educator/counsellor for patients; and
(b) 24-hour access by patients to medical advice; and
(c) an established liver clinic.

Authority required

Chronic hepatitis C infection

Treatment criteria:

- Must be treated in an accredited treatment centre.

Population criteria:

- Patient must be aged 18 years or older, **AND**
- Patient must not be pregnant or breastfeeding, and must be using an effective form of contraception if female and of child-bearing age.

Clinical criteria:

- Patient must have compensated liver disease, **AND**
- Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**
- Patient must have a contraindication to ribavirin, **AND**
- The treatment must cease unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**
- The treatment must be limited to a maximum duration of 48 weeks.

Evidence of chronic hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6449K	2	5	..	*2612.59	Pegasys [RO]

peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6439X	2	5	..	*2262.37	Pegasys [RO]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11044G	1	2	..	1329.87	Pegasys [RO]

Other immunostimulants

▪ PLERIXAFOR

Note Applications for increased maximum quantities will only be authorised for patients with body weight greater than 100 kg.

Authority required

Mobilisation of haematopoietic stem cells

Clinical criteria:

- The treatment must be in combination with granulocyte-colony stimulating factor (G-CSF), **AND**
- Patient must have lymphoma; OR
- Patient must have multiple myeloma, **AND**
- Patient must require autologous stem cell transplantation, **AND**
- Patient must have failed previous stem cell collection; OR
- Patient must be undergoing chemotherapy plus G-CSF mobilisation and their peripheral blood CD34+ count is less than 10,000 per millilitre or less than 10 million per litre on the day of planned collection; OR
- Patient must be undergoing chemotherapy plus G-CSF mobilisation and the first apheresis has yielded less than 1 million CD34+ cells/kg.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

plerixafor 24 mg/1.2 mL subcutaneous infusion injection, 1.2 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10084R	1	1	..	7038.15	Mozobil [GZ]

▪ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

▪ ABATACEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the

C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

abatacept 250 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9621J	1	..	..	284.14	Orencia [BQ]

▪ ALEMTUZUMAB

Note Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.
Note Special Pricing Arrangements apply.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must not receive more than one PBS-subsidised treatment per year, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

- Must be treated by a neurologist.

alemtuzumab 12 mg/1.2 mL injection, 1.2 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10246G	3	..	..	*34229.14	Lemtrada [GZ]

▪ ALEMTUZUMAB

Note Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.
Note Special Pricing Arrangements apply.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

alemtuzumab 12 mg/1.2 mL injection, 1.2 mL vial

10243D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	5	..	..	*57017.15	Lemtrada [GZ]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment, according to the specified dosage in the approved Product Information (PI).
Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis).
Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have active and progressing thrombotic microangiopathy (TMA) caused by aHUS, **AND**
- Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample taken prior to plasma exchange or infusion; or, if ADAMTS-13 activity was not collected prior to plasma exchange or infusion, patient must have platelet counts of greater than 30x10^9/L and a serum creatinine of greater than 150 mol/L, **AND**
- Patient must have a confirmed negative STEC (Shiga toxin-producing E.Coli) result if the patient has had diarrhoea in the preceding 14 days, **AND**
- Patient must have clinical features of active organ damage or impairment, **AND**
- Patient must not receive more than 4 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than 150x10^9/L; and evidence of two of the following:

(i) presence of schistocytes on blood film;

(ii) low or absent haptoglobin;

(iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) in recipients of a kidney transplant for end-stage kidney disease due to aHUS, a kidney biopsy confirming TMA; AND

(3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

(i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or

(ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or

(iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or

(iv) a renal biopsy consistent with aHUS;

(b) onset of TMA-related neurological impairment;

(c) onset of TMA-related cardiac impairment;

(d) onset of TMA-related gastrointestinal impairment;

(e) onset of TMA-related pulmonary impairment.

Claims of non-renal TMA-related organ damage should be made at the point of application for initial PBS-subsidised eculizumab (where possible), and should be supported by objective clinical measures. The prescriber's cover letter should establish that the observed organ damage is directly linked to active and progressing TMA, particularly when indirect causes such as severe thrombocytopenia, hypertension and acute renal failure are present at the time of the initial organ impairment.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment.

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form - Initial PBS-subsidised eculizumab treatment; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A detailed cover letter from the prescriber; and

(5) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(6) A measurement of body weight at the time of application; and

(7) The result of ADAMTS-13 activity on a blood sample taken prior to plasma exchange or infusion; the date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of any plasma exchanges or infusions that were undertaken in the two weeks prior to collection of the ADAMTS-13 assay; and

(8) In the case that a sample for ADAMTS-13 assay was not collected prior to plasma exchange or infusion, measurement of ADAMTS-13 activity must be taken 1-2 weeks following the last plasma exchange or infusion. The ADAMTS-13 result must be submitted to the Department of Human Services within 27 days of commencement of eculizumab treatment in order for the patient to be considered as eligible for further PBS-subsidised eculizumab treatment, under **Initial treatment 1-balance of supply**; and

(9) A confirmed negative STEC result if the patient has had diarrhoea in the preceding 14 days; and

(10) Evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records. All tests must have been performed within one month of application; and

(11) For all patients, a recent measurement of eGFR, platelets and two of either LDH, haptoglobin or schistocytes of no more than 1 week old at the time of application.

eculizumab 300 mg/30 mL injection, 30 mL vial

10182X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	5984.65	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 4 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis). Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of

haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment - Balance of Supply

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Clinical criteria:

- Patient must have received PBS-subsidised initial supply of eculizumab for this condition, **AND**
- Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample, **AND**
- Patient must not receive more than 20 weeks supply under this restriction.

ADAMTS-13 activity result must have been submitted to the Department of Human Services. In the case that a sample for ADAMTS-13 activity taken prior to plasma exchange or infusion was not available at the time of application for **Initial Treatment,** ADAMTS-13 activity must have been measured 1-2 weeks following the last plasma exchange or infusion, and must have been submitted to the Department of Human Services within 27 days of commencement of eculizumab. The date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of the last, if any, plasma exchange or infusion that was undertaken in the two weeks prior to collection of the ADAMTS-13 assay must also have been provided to Department of Human Services.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment.

eculizumab 300 mg/30 mL injection, 30 mL vial

10192K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	4	..	5984.65	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 6 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note For patients who have received continuing treatment with PBS-subsidised eculizumab prior to 1 January 2016, this restriction is limited to 28 weeks of therapy.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis).
Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available

on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Extended initial treatment - Assessment phase

Clinical criteria:

- Patient must have received treatment under the initial restriction with PBS subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 56 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure.

A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

A maximum of up to 56 weeks of treatment is allowed under this restriction, however an application must be submitted at 6 months, 12 months, 18 months and 24 months following commencing PBS-subsidised eculizumab.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Extended Initial treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before commencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant, if applicable, (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

eculizumab 300 mg/30 mL injection, 30 mL vial

10521R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	6	..	5984.65	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 5 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis). Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have received treatment under Extended Initial restriction with PBS subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure.

A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before recommencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Extended Continuing treatment

Clinical criteria:

- Patient must have received treatment under the Continuing treatment with PBS-subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response with PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must have a TMA-related cardiomyopathy as evidenced by left ventricular ejection fraction < 40% on current objective measurement; OR
- Patient must have severe TMA-related neurological impairment; OR
- Patient must have severe TMA-related gastrointestinal impairment; OR
- Patient must have severe TMA-related pulmonary impairment on current objective measurement; OR
- Patient must have grade 4 or 5 chronic kidney disease (eGFR of less than 30 mL/min); OR
- Patient must have a high risk of aHUS recurrence in the short term in the absence of continued treatment with eculizumab, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before commencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant, if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease; and

(11) A supporting statement with clinical evidence of severe TMA-related cardiomyopathy (including current LVEF result), neurological impairment, gastrointestinal impairment or pulmonary impairment; and

(12) Evidence that the patient has had a treatment response including haematological results of no more than 1 month old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 month old at the time of application; and

(13) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(14) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Note All applications should be accompanied by a detailed letter that outlines the objective evidence of high risk of critical organ damage if aHUS recurs. The following evidence may be submitted to establish the patient's level of risk of aHUS recurrence in the short term in the absence of continued treatment with eculizumab:

a) Evidence of a mutation known to confer a high risk of aHUS recurrence;

b) Past history of recurrent episodes of active and progressive TMA due to aHUS, prior to the episode that led to current use of eculizumab;

c) Past family history of aHUS recurrence, especially in first-degree relatives;

d) Past history of recurrent aHUS following renal transplant for end-stage renal failure due to aHUS.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have demonstrated treatment response to previous treatment with PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must have the following clinical conditions:(i) either significant haemolysis as measured by low/absent haptoglobin; or presence of schistocytes on the blood film; or lactate dehydrogenase (LDH) above normal;AND(ii) either platelet consumption as measured by either 25% decline from patient baseline or thrombocytopenia (platelet count <150 x 10^9/L);OR(iii) TMA-related organ impairment including on recent biopsy, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form(s); and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Recommencement of treatment; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A detailed cover letter from the prescriber; and

(5) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(6) A measurement of body weight at the time of application, and

(7) An identified genetic mutation, if applicable; and

(8) A family history of aHUS if applicable; and

(9) A history of multiple episodes of aHUS following the treatment break, if applicable; and

(10) A history of kidney transplant if applicable (especially if required due to aHUS); and

(11) An inclusion of the individual consequences of recurrent disease; and

(12) A supporting statement with clinical evidence of TMA-related organ damage including current (within one week of application) haematological results (platelet count, haptoglobin and LDH), eGFR level, and, if applicable, on recent biopsy;

(13) Evidence that the patient has had a treatment response to their previous treatment with eculizumab; and

(14) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(15) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Note A raise in LDH alone is not a sufficient reason to re-commence eculizumab, but thrombocytopenia with one marker of haemolysis (such as raised LDH, presence of schistocytes, or low/absence of haptoglobin) is an accepted reason to consider re-commencement of eculizumab treatment.

Note Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab treatment.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing recommencement of treatment

Clinical criteria:

- Patient must have received treatment under Recommencement of treatment restriction with PBS-subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated ongoing treatment response to the previous 24 weeks of PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before recommencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

eculizumab 300 mg/30 mL injection, 30 mL vial

10194M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	5984.65	Soliris [XI]

▪ EVEROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required
Management of renal allograft rejection
Treatment Phase: Management (initiation, stabilisation and review of therapy)
Clinical criteria:
- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required
Management of cardiac allograft rejection
Treatment Phase: Management (initiation, stabilisation and review of therapy)
Clinical criteria:
- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

everolimus 500 microgram tablet, 60

6460B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*956.81	Certican [NV]

everolimus 750 microgram tablet, 60

6461C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	5	..	*2786.59	Certican [NV]

everolimus 1 mg tablet, 60

9582H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	5	..	*3699.71	Certican [NV]

everolimus 250 microgram tablet, 60

6459Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*481.99	Certican [NV]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Authority required
Management of renal allograft rejection
Treatment Phase: Management (initiation, stabilisation and review of therapy)
Clinical criteria:
- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required
Management of cardiac allograft rejection
Treatment Phase: Management (initiation, stabilisation and review of therapy)
Clinical criteria:
- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

mycophenolate mofetil 500 mg tablet, 50

6209T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	6	5	..	*281.47	[a] APO-Mycophenolate [TX] [a] Ceptolate [AF] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Mycophenolate AN [EA] [a] Pharmacor Mycophenolate 500 [CR]

mycophenolate mofetil 1 g/5 mL powder for oral liquid, 165 mL

6364Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*#518.46	CellCept [RO]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Note Management includes initiation, stabilisation and review of therapy as required.

Authority required
Prophylaxis of renal allograft rejection
Treatment Phase: Management
Clinical criteria:
- The treatment must be under the supervision and direction of a transplant unit.

Authority required
WHO Class III, IV or V lupus nephritis
Treatment Phase: Management
Clinical criteria:

- The condition must be proven by biopsy.

Treatment criteria:

- Must be treated by a nephrologist or in consultation with a nephrologist.

The name of the consulting nephrologist must be included in the patient medical records.

mycophenolate 360 mg enteric tablet, 120

6370G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*363.99	Myfortic [NV]

mycophenolate 180 mg enteric tablet, 120

6369F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*185.59	Myfortic [NV]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Note For item codes 6208R and 1837Q, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

Authority required

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required

Management of cardiac allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

mycophenolate mofetil 250 mg capsule, 100

6208R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6	5	..	*281.59	[a] APO-Mycophenolate [TX] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Pharmacor Mycophenolate 250 [CR]

mycophenolate Capsule 250 mg, 50

1837Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
12	5	..	*281.59	[a] Ceptolate [AF]

▪ NATALIZUMAB

Caution Progressive multifocal leukoencephalopathy has been reported with this drug.

Authority required

Clinically definite relapsing-remitting multiple sclerosis

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must be ambulatory (without assistance or support), **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to multiple sclerosis, in the preceding 2 years, **AND**
- The condition must be confirmed by magnetic resonance imaging of the brain and/or spinal cord; OR
- Patient must be deemed unsuitable for magnetic resonance imaging due to the risk of physical (not psychological) injury to the patient.

Population criteria:

- Patient must be aged 18 years or older.

The date of the magnetic resonance imaging scan must be included in the patient's medical notes, unless written certification is provided, in the patient's medical notes, by a radiologist that an MRI scan is contraindicated because of the risk of physical (not psychological) injury to the patient.

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

Authority required

Clinically definite relapsing-remitting multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**

- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate, this therapy.

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

natalizumab 300 mg/15 mL injection, 15 mL vial

9624M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	1536.79	Tysabri [BD]

▪ OCRELIZUMAB

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

- Must be treated by a neurologist.

ocrelizumab 300 mg/10 mL injection, 10 mL vial

11237K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*17580.15	Ocrevus [RO]

▪ SIROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

sirolimus 1 mg/mL oral liquid, 60 mL

6437T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*931.91	Rapamune [PF]

sirolimus 1 mg tablet, 100

6436R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1421.47	Rapamune [PF]

sirolimus 2 mg tablet, 100

6457W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2795.83	Rapamune [PF]

sirolimus 500 microgram tablet, 100

9748C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*721.81	Rapamune [PF]

▪ VEDOLIZUMAB

Note Special Pricing Arrangements apply.

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle. A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .

(a) Initial treatment. Applications for initial treatment should be made where:

(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).

Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.

A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab,

vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.
For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient – Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**
- Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, and followed by a failure to achieve an adequate response to 3 or more months of treatment of an appropriately dosed thiopurine agent, **AND**
- Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR
- Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Mayo clinic or partial Mayo clinic calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment.

The most recent Mayo clinic or partial Mayo clinic score must be no more than 1 month old at the time of application.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose for patients administered doses at weeks 0, 2 and 6 (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

Patients must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Note Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Patients who have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

Note No applications for increased repeats will be authorised.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Change or Re-commencement of treatment after a break in therapy (Initial 2)

Clinical criteria:

- Patient must have previously been issued with an authority prescription for adalimumab, infliximab or vedolizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with vedolizumab for this condition more than once in the current treatment cycle, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Population criteria:

- Patient must be aged 18 years or older.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of this drug within the timelines specified in the relevant restriction. If the response assessment to the previous course of this drug is not submitted as detailed in the relevant restriction, the patient will be deemed to have failed therapy with this drug.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses of treatment may be requested by telephone by contacting the Department of Human Services.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (Change or Recommencement of treatment after a break in therapy) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (Initial 1 and Initial 2 restrictions) or 2 repeats (Continuing restriction), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial PBS-subsidised treatment (Grandfather patient)

Clinical criteria:

- Patient must have previously received non-PBS-subsidised therapy with this drug for this condition prior to 1 August 2015, **AND**
- Patient must have had a Mayo clinic score greater than or equal to 6 prior to commencing treatment with this drug; OR
- Patient must have had a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores were both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo score) prior to commencing treatment with this drug; OR
- Patient must have a documented history of moderate to severe refractory ulcerative colitis prior to having commenced treatment with this drug where a Mayo clinic, partial Mayo clinic baseline assessment is not available, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be 18 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and baseline Mayo clinic or partial Mayo clinic calculation sheet including the date of assessment of the patient's condition; and

(ii) the date of commencement of this drug; and

(iii) the signed patient acknowledgement.

The current Mayo clinic or partial Mayo clinic assessment must be no more than 1 month old at the time of application. The baseline assessment must be from immediately prior to commencing treatment with this drug. Where a baseline assessment is not available the prescriber must contact the Department of Human Services to discuss.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note The patient must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

vedolizumab 300 mg injection, 1 vial

10398G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	3152.34	Entyvio [TK]

▪ VEDOLIZUMAB

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of

Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient – initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application and should be performed preferably whilst still on conventional treatment, but no longer than 1 month following cessation of the most recent prior treatment

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

Note This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

HSD (Private)

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Initial PBS-subsidised treatment (Grandfather)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously received non-PBS-subsidised therapy with this drug for this condition prior to 1 August 2015.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have had a Crohn Disease Activity Index (CDAI) Score of greater than or equal to 300 prior to commencing treatment with this drug; OR
- Patient must have a documented history of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have a documented history and radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide sufficient for a single infusion of 300 mg vedolizumab per dose. Up to a maximum of 2 repeats will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug to complete 24 weeks of treatment under the Initial PBS-subsidised treatment restriction for patients who had previously received non-PBS subsidised treatment (Grandfathered patient), **AND**

- The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing or Grandfathered patients), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Note Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests and diagnostic imaging studies, must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide sufficient for a single infusion of 300 mg vedolizumab per dose. Up to a maximum of 2 repeats will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

vedolizumab 300 mg injection, 1 vial

10415E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	3152.34	Entyvio [TK]

Tumor necrosis factor alpha (TNF-) inhibitors

▪ ADALIMUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete

remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the

first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**
- Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

9678J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1327.01	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9680L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1327.01	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9679K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1327.01	Humira [VE]

▪ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human

Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient

will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with etanercept, **AND**
- Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24

weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9615C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	983.97	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9641K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	983.97	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

6367D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	495.57	Enbrel [PF]

▪ INFLIXIMAB

Note No increase in the maximum number of repeats may be authorised.

Authority required

Acute severe ulcerative colitis

Treatment criteria:

- Must be treated by a gastroenterologist; OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology, or general medicine specialising in gastroenterology].

Clinical criteria:

- Patient must have received an infusion of infliximab for the treatment of this condition as a hospital inpatient no more than two weeks prior to the date of the authority application, **AND**
- Patient must be an adult aged 18 years or older, and prior to initiation of infliximab treatment in hospital must have been experiencing six or more bloody stools per day, plus at least one of the following: (i) Temperature greater than 37.8 degrees Celsius; (ii) Pulse rate greater than 90 beats per minute; (iii) Haemoglobin less than 105 g/L; (iv) Erythrocyte sedimentation rate greater than 30 mm/h; OR
- Patient must be a child aged 6 to 17 years inclusive, and prior to initiation of infliximab treatment in hospital must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) greater than or equal to 65, with the diagnosis confirmed by a gastroenterologist, or a consultant physician as specified below, **AND**
- Patient must have failed to achieve an adequate response to at least 72 hours treatment with intravenous corticosteroids prior to initiation of infliximab treatment in hospital.

Population criteria:

- Patient must be 6 years of age or older.

For adults aged 18 years or older, failure to achieve an adequate response to intravenous corticosteroid treatment is defined by the Oxford criteria where:

(i) If assessed on day 3, patients pass 8 or more stools per day or 3 or more stools per day with a C-reactive protein (CRP) greater than 45 mg/L

(ii) If assessed on day 7, patients pass 3 or more stools per day with visible blood.

For children aged 6 to 17 years, failure to achieve an adequate response to intravenous corticosteroids means a PUCAI score greater than 45 at 72 hours.

At the time of authority application, prescribers should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Before administering infliximab to a child aged 6 to 17 years, the treating clinician must have consulted with a paediatric gastroenterologist or with an institution experienced in performance of paediatric colectomy. The name of the specialist or institution must be included in the patient's medical records.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

infliximab 100 mg injection, 1 vial

10057H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Note TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.
From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.
A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.
A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6 will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

The authority application must be made in writing

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and

(c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

The authority application must be made in writing

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

(a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with infliximab prior to 1 March 2010; and

(b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with infliximab; and

(c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) is receiving treatment with infliximab at the time of application; and

(e) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with infliximab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

The authority application must be made in writing

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

The authority application must be made in writing

infliximab 100 mg injection, 1 vial

9674E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

HSD (Private)

▪ INFLIXIMAB

Note TREATMENT OF PAEDIATRIC PATIENTS WITH REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with adalimumab for severe refractory Crohn disease and infliximab for moderate to severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time.

For paediatric patients with Crohn disease, infliximab is PBS-subsidised for moderate to severe disease while adalimumab is PBS-subsidised for severe disease.

From 1 August 2015, under the PBS, patients commencing on adalimumab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to infliximab. Patients on infliximab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist but will need to meet a PCDAI score of greater than or equal to 40 when swapping to adalimumab. Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2015 is considered to be in their first cycle as of 1 August 2015.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2015.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2015, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to theDepartment of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an

HSD (Private)

adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient with severe disease may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Crohn Disease Activity Index (PCDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy, immunosuppressive therapy or enteral nutrition.
Patients on infliximab may swap to adalimumab within the same treatment cycle provided that their disease severity has progressed to severe disease (i.e. they have a current PCDAI score of 40 or more).
A patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PCDAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
Patients must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months immediately prior to the time the PCDAI score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe Crohn disease

Treatment Phase: Initial treatment (new paediatric patient) of Crohn disease in a paediatric patient assessed by PCDAI (Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist, consultant physician, paediatrician or specialist paediatric gastroenterologist, **AND**
- Patient must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contra-indication to each of prednisolone (or equivalent), azathioprine, 6-mercaptopurine and methotrexate, **AND**

- Patient must have, at the time of application, disease severity considered to be moderate to severe as demonstrated by a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 30 preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment and which is no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription forms; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of previous systemic drug therapy [dosage, date of commencement and duration of therapy] or dates of enteral nutrition; and

(iii) the signed patient or guardian acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application. If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Human Services website (www.humanservices.gov.au).

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Change or re-commencement of treatment of Crohn disease in a paediatric patient assessed by PCDAI (Initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have a documented history of moderate to severe Crohn disease, **AND**
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with this drug for this condition; OR
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with adalimumab for this condition, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition more than once in the current treatment cycle.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) Score calculation sheet; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Continuing treatment of Crohn disease in a paediatric patient assessed by PCDAI

Clinical criteria:

- Patient must have a documented history of moderate to severe Crohn disease.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug as defined as a reduction in PCDAI Score by at least 15 points as compared to baseline and a total of PCDAI score of 30 points or less with the PCDAI assessment being no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition.

The PCDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with this drug, a PCDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the 'Balance of Supply' treatment phase PBS restriction.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Balance of supply for a paediatric patient

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under Initial 1 (new patient or patient recommencing treatment after break of more than 5 years) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) or Continuing treatment to complete the maximum duration of treatment specified in the relevant treatment phase, **AND**
- The treatment must provide no more than the balance of up to 3 doses or 2 repeats.

Note Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
9612X	1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction.

Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing treatment).

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Population criteria:

- Patient must be aged 18 years or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

Up to a maximum of 2 repeats will be authorised.

infliximab 100 mg injection, 1 vial

9613Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle. A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .

(a) Initial treatment. Applications for initial treatment should be made where:

(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).

Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.

A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to

the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab, vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.
For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Note TREATMENT OF PAEDIATRIC PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with infliximab or adalimumab for moderate to severe ulcerative colitis; and infliximab for acute severe ulcerative colitis. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to infliximab and adalimumab only.A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time. Infliximab and adalimumab are PBS-subsidised for moderate to severe disease while only infliximab is PBS-subsidised for acute severe disease.From 1 June 2017, under the PBS, all will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent.Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 June 2017 is considered to be in their first cycle as of 1 June 2017. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle. A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle. There is no limit to the number of treatment cycles a patient may undertake in their lifetime.(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 June 2017.(a) Initial treatment.Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or (ii) a patient has received prior PBS-subsidised (initial or continuing) treatment with a TNF-alfa antagonist and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping treatment' below]; or (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2). Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of treatment for adalimumab and 14 weeks of treatment for infliximab. From 1 June 2017, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted tothe Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6

HSD (Private)

doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply. Assessments of response to a course of PBS-subsidised treatment must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.(2) Swapping treatment. Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Ulcerative Colitis Activity Index (PUCAI) Score, confirmation of ulcerative colitis disease), or the prior conventional therapies of corticosteroids or immunosuppressives.A patient may trial an alternate agent at any time, regardless of whether they are receiving treatment (initial or continuing) with infliximab or adalimumab at the time of the application. However, a patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PUCAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the PUCAI score is measured.(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab. A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 June 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction. 'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient or Recommencement of treatment after more than 5 years break in therapy - Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**
- Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg (for a child, 1 to 2 mg/kg up to 40 mg) prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, and followed by a failure to achieve an adequate response to 3 or more months of treatment of an appropriately dosed thiopurine agent, **AND**
- Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR
- Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score); OR
- Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 if aged 6 to 17 years; OR
- Patient must have previously received induction therapy with this drug for an acute severe episode of ulcerative colitis in the last 4 months and demonstrated an adequate response to induction therapy by achieving and maintaining a partial

Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a PUCAI score less than 10 (if aged 6 to 17 years).

Population criteria:

- Patient must be 6 years of age or older.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement or guardian acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, or to be administered at 8-weekly intervals for patients who have received prior treatment for an acute severe episode, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment.

The most recent Mayo clinic, partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) score must be no more than 1 month old at the time of application.

Where treatment for an acute severe episode has occurred, an adequate response to induction therapy needs to be demonstrated by achieving and maintaining a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 (if aged 6 to 17 years), within the first 12 weeks of receiving this drug for acute severe ulcerative colitis.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 within the first 12 weeks of receiving this drug for ulcerative colitis, or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose for patients administered doses at weeks 0, 2 and 6 (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The patient or guardian (required if patient is aged 6 to 17 years) must have signed a patient acknowledgement indicating that he or she understands and acknowledges that the PBS-subsidised treatment will cease if he or she does not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR
- Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score of less than 10 while receiving treatment with this drug, if aged 6 to 17 years.

Patients who have failed to maintain a partial Mayo clinic score of less than or equal to 2, with no subscore greater than 1, or, patients who have failed to maintain a Paediatric Ulcerative Colitis Activity Index (PUCAI) score of less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

The authority application must be made in writing

Up to a maximum of 2 repeats will be authorised.

Note No applications for increased repeats will be authorised.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Change or Re-commencement of treatment after a break in therapy (Initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with adalimumab, infliximab or vedolizumab for this condition in this treatment cycle; OR
- Patient must have previously received PBS-subsidised treatment with adalimumab or infliximab for this condition in this treatment cycle if aged 6 to 17 years, **AND**
- Patient must not have failed PBS-subsidised treatment with infliximab for this condition in the current treatment cycle; OR
- Patient must not have failed PBS-subsidised treatment with infliximab for this condition in the current treatment cycle more than once if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of this drug within the timelines specified in the relevant restriction. If the response assessment to the previous course of this drug is not submitted as detailed in the relevant restriction, the patient will be deemed to have failed therapy with this drug.

Applications for authorisation of initial treatment must be in writing and must include:(a) a completed authority prescription form; and(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy];

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Up to a maximum of 2 repeats will be authorised.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR

- Patient must have received insufficient therapy with this drug under the Initial 2 (Change or Recommencement of treatment after a break in therapy) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (Initial 1 and Initial 2 restrictions) or 2 repeats (Continuing restriction).

Population criteria:

- Patient must be 6 years of age or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

infliximab 100 mg injection, 1 vial

10184B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have

HSD (Private)

demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must have not failed previous PBS-subsidised treatment with infliximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i)

hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application including severity.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;

(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to a treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient infliximab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient infliximab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 22 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with infliximab, **AND**
- Patient must have received infliximab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 2 repeats will be authorised.

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient infliximab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

6397Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.
Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.
Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender,

AND

- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

---

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

- Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 18 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6448J	1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 22 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

infliximab 100 mg injection, 1 vial

6496X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.
Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.
Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.
Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.
There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.
(1) Application for approval for initial treatment.
Applications for a course of initial treatment should be made in the following situations:
(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or
(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.
Grandfather patients (ixekizumab only).
Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.
Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.
(2) Assessment of response to initial treatment.
When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.
The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.
(3) Application for continuing treatment.
Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.
For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.
Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.
(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by

the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment - Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR

- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 22 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

---

infliximab 100 mg injection, 1 vial

9617E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	534.87	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

Interleukin inhibitors

▪ ANAKINRA

Note This drug is not PBS-subsidised for conditions other than CAPS.

Authority required (STREAMLINED)

5450

Moderate to severe cryopyrin associated periodic syndromes (CAPS)

Treatment criteria:

- Must be treated by a rheumatologist or in consultation with a rheumatologist; OR
- Must be treated by a clinical immunologist or in consultation with a clinical immunologist.

A diagnosis of CAPS must be documented in the patient's medical records.

anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes

10263E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	1697.15	Kineret [FK]

▪ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply.

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

10079L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	272.00	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

10068X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	114.00	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

10060L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	534.16	Actemra [RO]

▪ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR
- Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive

DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing)

with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure

uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

10071C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	272.00	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

10073E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	114.00	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

10078K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	534.16	Actemra [RO]

▪ TOCILIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD

therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with tocilizumab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to a treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

9672C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	272.00	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

9671B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	114.00	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

9673D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	534.16	Actemra [RO]

▪ TOCILIZUMAB

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tocilizumab for a patient who has severe active systemic juvenile idiopathic arthritis (sJIA).

From 1 May 2012, a patient receiving PBS-subsidised tocilizumab therapy is considered to be in a treatment cycle. Under these arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with PBS-subsidised tocilizumab while they continue to show a response to therapy, and

(ii) fail to respond, or to sustain a response, to PBS-subsidised tocilizumab twice.

Once a patient has either failed or ceased to respond to 2 courses of treatment, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised tocilizumab therapy before they are eligible to receive further PBS-subsidised tocilizumab therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised tocilizumab treatment was stopped to the date of the first application for initial treatment with tocilizumab under the new treatment cycle.

A patient who was receiving PBS-subsidised tocilizumab treatment immediately prior to 1 May 2012 is considered to be in their first cycle as of 1 May 2012. A patient who has had a break in tocilizumab treatment of at least 12 months immediately prior to making a new application, on or after 1 May 2012, will commence a new treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of less than 12 months may commence a second course of treatment within the same treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

(1) How to prescribe PBS-subsidised tocilizumab therapy after 1 May 2012.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised tocilizumab treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to recommence treatment with tocilizumab following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received the first course of PBS-subsidised (initial or continuing) tocilizumab therapy in a treatment cycle and is deemed to have failed to respond or sustain a response and the treating physician wishes to trial a second course, provided any break in therapy is less than 12 months (Initial 2); or

(iv) a patient wishes to recommence treatment with tocilizumab following a break in PBS-subsidised therapy of less than 12 months (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab for that course.

For second and subsequent courses of PBS-subsidised tocilizumab, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with tocilizumab, a patient may qualify to receive up to 24 weeks of continuing treatment with tocilizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted tocilizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

(2) Treatment cycle.

Once initial treatment with PBS-subsidised tocilizumab is approved, a patient deemed to have failed to respond to the first course of treatment may have a second course without having to requalify with respect to the indices of disease severity (joint count, fever and/or CRP level and platelet count) or the prior therapy requirements, except if the patient has had a break in therapy of more than 12 months.

To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the relevant baseline measurements of the joint count, fever and/or CRP level and platelet count submitted with the first authority application for tocilizumab.

Where a patient is deemed to have failed to respond or to sustain a response to the first course of therapy in a treatment cycle, prescribers may provide new baseline measurements for the second course of treatment within that cycle. The Department of Human Services will assess response according to these revised baseline measurements. If new baseline measurements are not submitted with the initial application for the second course of treatment, then those submitted with the first course will be used by the Department of Human Services to assess response to the second course.

(4) Recommencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised tocilizumab therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with tocilizumab should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

- Patient must have been diagnosed with systemic juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with tocilizumab for this condition; OR
- Patient must not have received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have polyarticular course disease which has failed to respond adequately to oral or parenteral methotrexate at a dose of at least 15 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; OR
- Patient must have polyarticular course disease and have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have refractory systemic symptoms, demonstrated by an inability to decrease and maintain the dose of prednisolone (or equivalent) below 0.5 mg per kg per day following a minimum of 2 months of therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

The following criteria indicate failure to achieve an adequate response to prior methotrexate therapy in a patient with polyarticular course disease and must be demonstrated in the patient at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The following criteria indicate failure to achieve an adequate response to prior therapy in a patient with refractory systemic symptoms and must be demonstrated in the patient at the time of the initial application:

(a) an active joint count of at least 2 active joints; and

(b) persistent fever greater than 38 degrees Celsius for at least 5 out of 14 consecutive days; and/or

(c) a C-reactive protein (CRP) level and platelet count above the upper limits of normal (ULN).

The baseline measurements of joint count, fever and/or CRP level and platelet count must be performed preferably whilst on treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with other treatments is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes the following:

(i) the date of assessment of severe active systemic juvenile idiopathic arthritis;

(ii) details of prior treatment including dose and duration of treatment;

(iii) pathology reports detailing CRP and platelet count where appropriate; and

(3) an acknowledgement signed by a parent or authorised guardian.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to 2 courses of treatment in a treatment cycle they will not be eligible to receive further PBS-subsidised tocilizumab therapy in that treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

HSD (Private)

Note To ensure consistency in determining response, the same indices of disease severity used to establish baseline must be provided for all subsequent continuing treatment applications.

Note Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (retrial or recommencement of treatment after a break of less than 12 months)

Clinical criteria:

- Patient must have a documented history of systemic juvenile idiopathic arthritis, **AND**
- Patient must have received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months, **AND**
- Patient must not have failed to demonstrate an adequate response to PBS-subsidised therapy with tocilizumab for this condition more than once in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes pathology reports detailing C-reactive protein (CRP) level and platelet count where appropriate.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to that course of treatment with tocilizumab.

An adequate response to treatment is defined as:

(a) in a patient with polyarticular course disease:

(i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

- elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

- shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) absence of fever greater than 38 degrees Celsius in the preceding seven days; and/or

(ii) a reduction in the C-reactive protein (CRP) level and platelet count by at least 30% from baseline; and/or

(iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Note Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (retrial or recommencement of treatment after a break of less than 12 months) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy under the Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy under the Initial 2 (retrial or recommencement of treatment after a break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of systemic juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to their most recent course of PBS-subsidised treatment with tocilizumab, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

An adequate response to treatment is defined as:

(a) in a patient with polyarticular course disease:

(i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

- elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

- shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) absence of fever greater than 38 degrees Celsius in the preceding seven days; and/or

(ii) a reduction in the C-reactive protein (CRP) level and platelet count by at least 30% from baseline; and/or

(iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurements of disease severity submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes baseline and current pathology reports detailing CRP and platelet count where appropriate.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the most recent prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Note An assessment of the patient's response to a continuing course of therapy should be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

1423X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	272.00	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

1419Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	114.00	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

1464C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	534.16	Actemra [RO]

▪ USTEKINUMAB

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).

Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.

From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.

A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.

From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.

For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.

Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.

A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or

continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug, **AND**
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**

- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for 2 vials of 45 mg and no repeats.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent first dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

ustekinumab 130 mg/26 mL injection, 26 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11164N	4	..	..	*16976.39	Stelara [JC]

Calcineurin inhibitors

▪ CICLOSPORIN

Caution Careful monitoring of patients is mandatory.

Authority required

Management of transplant rejection

Clinical criteria:

- The treatment must be used by organ or tissue transplant recipients.

ciclosporin 50 mg/mL injection, 10 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6109M	1	..	..	65.25	Sandimmun [NV]

▪ CICLOSPORIN

Caution Careful monitoring of patients is mandatory.

Authority required

Management of transplant rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must have had an organ or tissue transplantation, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required

Severe atopic dermatitis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Treatment criteria:

- Must be treated by a dermatologist; OR
- Must be treated by a clinical immunologists.

Clinical criteria:

- The condition must be ineffective to other systemic therapies; OR
- The condition must be inappropriate for other systemic therapies.

Authority required

Severe psoriasis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- The condition must be ineffective to other systemic therapies; OR
- The condition must be inappropriate for other systemic therapies, **AND**

- The condition must have caused significant interference with quality of life.

Treatment criteria:

- Must be treated by a dermatologist.

Authority required

Nephrotic syndrome

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must have failed prior treatment with steroids and cytostatic drugs; OR
- Patient must be intolerant to treatment with steroids and cytostatic drugs; OR
- The condition must be considered inappropriate for treatment with steroids and cytostatic drugs, **AND**
- Patient must not have renal impairment.

Treatment criteria:

- Must be treated by a nephrologist.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- The condition must have been ineffective to prior treatment with classical slow-acting anti-rheumatic agents (including methotrexate); OR
- The condition must be considered inappropriate for treatment with slow-acting anti-rheumatic agents (including methotrexate).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist.

ciclosporin 10 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6232B	2	5	..	*85.55	Neoral 10 [NV]

ciclosporin 50 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6353J	4	5	..	*286.03	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 50 [NV]

ciclosporin 100 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6354K	4	5	..	*575.39	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 100 [NV]

ciclosporin 25 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6352H	4	5	..	*141.19	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 25 [NV]

ciclosporin 100 mg/mL oral liquid, 50 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6125J	4	5	..	*1310.31	Neoral [NV]

▪ TACROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required

Management of rejection in patients following organ or tissue transplantation

Clinical criteria:

- The treatment must be under the supervision and direction of a transplant unit, **AND**
- The treatment must include initiation, stabilisation, and review of therapy as required.

tacrolimus 1 mg modified release capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
9682N	2	5	..	*280.97	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 5 mg capsule, 50

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6217F	2	5	..	*1143.59	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 500 microgram modified release capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
9681M	2	5	..	*86.19	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 750 microgram capsule, 100

10875J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*397.15	Tacrolimus Sandoz [SZ]

tacrolimus 5 mg modified release capsule, 30

9683P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*787.61	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 500 microgram capsule, 100

6328C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*235.33	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 0.5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 1 mg capsule, 100

6216E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*463.51	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 1 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 2 mg capsule, 100

10879N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1047.15	Tacrolimus Sandoz [SZ]

Other immunosuppressants

▪ LENALIDOMIDE

Note Special Pricing Arrangements apply.

Authority required

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be limited to a maximum duration of 16 weeks, **AND**
- Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**
- Patient must be red blood cell transfusion dependent.

Classification of a patient as Low risk requires a score of 0 on the IPSS, achieved with the following combination: less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias.

Classification of a patient as Intermediate-1 requires a score of 0.5 to 1 on the IPSS, achieved with the following possible combinations:

1. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias; OR
2. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
3. less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
4. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 2/3 cytopenias; OR
5. 5%-10% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
6. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
7. less than 5% marrow blasts with poor karyotypic status (complex, greater than 3 abnormalities), and 0/1 cytopenias.

Classification of a patient as red blood cell transfusion dependent requires that:

(i) the patient has been transfused within the last 8 weeks; and

(ii) the patient has received at least 8 units of red blood cell in the last 6 months prior to commencing PBS-subsidised therapy with lenalidomide; and would be expected to continue this requirement without lenalidomide treatment.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Myelodysplastic Syndrome Lenalidomide Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and

(d) a copy of the full blood examination report; and

(e) a copy of the pathology report detailing the cytogenetics demonstrating Low risk or Intermediate-1 disease according to the IPSS (note: using Fluorescence in Situ Hybridization (FISH) to demonstrate MDS -5q is acceptable); and

(f) details of transfusion requirements including: (i) the date of most recent transfusion and the number of red blood cell units transfused; and (ii) the total number of red cell units transfused in the 4 and 6 months preceding the date of this application; and

(g) a signed patient acknowledgement form.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available

on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**
- Patient must have received PBS-subsidised initial therapy with lenalidomide for myelodysplastic syndrome, **AND**
- Patient must have achieved and maintained transfusion independence; or least a 50% reduction in red blood cell unit transfusion requirements compared with the four month period prior to commencing initial PBS-subsidised therapy with lenalidomide, **AND**
- Patient must not have progressive disease.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The first authority application for continuing supply must be made in writing. Subsequent authority applications for continuing supply may be made by telephone.

The following evidence of response must be provided at each application:

(i) a haemoglobin level taken within the last 4 weeks; and

(ii) the date of the last transfusion; and

(iii) a statement of the number of units of red cells transfused in the 4 months immediately preceding this application; and

(iv) a statement confirming that the patient has not progressed to acute myeloid leukaemia.

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Subsequent authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

lenalidomide 5 mg capsule, 21

2798G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	3	..	5169.91	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

2796E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	3	..	5408.31	Revlimid [CJ]

▪ LENALIDOMIDE

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial PBS-subsidised treatment

Clinical criteria:

- The condition must be confirmed by a histological diagnosis, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with dexamethasone, **AND**
- Patient must have progressive disease after at least one prior therapy, **AND**
- Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, prior treatments including name(s) of drug(s) and date of most recent treatment cycle and record of prior stem cell transplant or ineligibility for prior stem cell transplant; details of the basis of the diagnosis of progressive disease or failure to respond; and nomination of which disease activity parameters will be used to assess response; and

(3) a signed patient acknowledgment.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

(a) the level of serum monoclonal protein; or

(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or

(c) the serum level of free kappa and lambda light chains; or

(d) bone marrow aspirate or trephine; or

(e) if present, the size and location of lytic bone lesions (not including compression fractures); or

(f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or

(g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Multiple myeloma

Treatment Phase: Continuing PBS-subsidised treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for relapsed or refractory multiple myeloma, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with dexamethasone, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

lenalidomide 15 mg capsule, 21

9644N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6299.68	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

9642L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5169.91	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

9645P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6634.64	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

9643M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5408.31	Revlimid [CJ]

▪ LENALIDOMIDE

Caution This drug is a category X drug and must not be given to pregnant women. If lenalidomide is taken during pregnancy, a teratogenic effect of lenalidomide in humans cannot be ruled out.

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be newly diagnosed, **AND**
- The condition must be confirmed by a histological diagnosis, **AND**
- Patient must be ineligible for a primary stem cell transplantation, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues, **AND**
- The treatment must be in combination with dexamethasone.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, and ineligibility for prior stem cell transplant; and nomination of which disease activity parameters will be used to assess response; and

(3) a signed patient acknowledgement.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

(a) the level of serum monoclonal protein; or

(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or

(c) the serum level of free kappa and lambda light chains; or

(d) bone marrow aspirate or trephine; or

(e) if present, the size and location of lytic bone lesions (not including compression fractures); or

(f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or

(g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Patient must be registered in the i-access risk management program.

Authority required

Multiple myeloma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been authorised with a PBS prescription with this drug for the condition, **AND**
- Patient must not have demonstrated progressive disease, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues, **AND**
- The treatment must be in combination with dexamethasone.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

lenalidomide 15 mg capsule, 21

11042E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6299.68	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

11036W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5169.91	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

11055W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6634.64	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

11063G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5408.31	Revlimid [CJ]

▪ POMALIDOMIDE

Caution This drug is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be in combination with dexamethasone, **AND**
- Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**
- Patient must have experienced treatment failure with lenalidomide, **AND**
- Patient must have experienced treatment failure with bortezomib, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Bortezomib treatment failure is the absence of achieving at least a partial response or as progressive disease during treatment or within 6 months of discontinuing treatment with bortezomib. Lenalidomide treatment failure is progressive disease during treatment or within 6 months of discontinuing treatment with lenalidomide.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma pomalidomide Authority Application Supporting Information form; and

(3) reports demonstrating the patient has failed treatment with lenalidomide and bortezomib.

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Multiple myeloma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have progressive disease, **AND**
- The treatment must be in combination with dexamethasone, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pomalidomide 3 mg capsule, 21

10417G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	10547.15	Pomalyst [CJ]

pomalidomide 4 mg capsule, 21

10386P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	10547.15	Pomalyst [CJ]

▪ RITUXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-

subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed

whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with rituximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made at least 12 weeks after the first infusion so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services within 4 weeks of the date it was

conducted. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient who fails to demonstrate a response to treatment with rituximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who fails to demonstrate a response to rituximab treatment and who qualifies to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with rituximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised rituximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised rituximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response at least 12 weeks after the first infusion. This assessment must be submitted no later than 4 weeks from the date of the assessment.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient fails to demonstrate a response to a treatment with rituximab and who qualify to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as the most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

rituximab 500 mg/50 mL injection, 50 mL vial

9611W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1874.09	Mabthera [RO]

▪ THALIDOMIDE

Caution Thalidomide is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Note Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.

Authority required

Multiple myeloma

thalidomide 100 mg capsule, 28

9684Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*1643.15	Thalomid [CJ]

thalidomide 50 mg capsule, 28

6469L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	..	..	*1643.15	Thalomid [CJ]

MUSCULO-SKELETAL SYSTEM

MUSCLE RELAXANTS

MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS

Other centrally acting agents

BACLOFEN

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity of cerebral origin.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to multiple sclerosis.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord injury.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord disease.

baclofen 40 mg/20 mL intrathecal injection, 20 mL ampoule

11194E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*1043.83	Sintetica Baclofen Intrathecal [BZ]

BACLOFEN

Note Pharmaceutical benefits that have the form baclofen 10 mg/5 mL intrathecal injection, 5 mL ampoule and pharmaceutical benefits that have the form baclofen 10 mg/5 mL intrathecal injection, 10 x 5 mL ampoules are equivalent for the purposes of substitution.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity of cerebral origin.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to multiple sclerosis.

Authority required
Severe chronic spasticity
Clinical criteria:
- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**

- Patient must have chronic spasticity due to spinal cord injury.

Authority required

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord disease.

baclofen 10 mg/5 mL intrathecal injection, 5 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6284R	10	..	..	*1293.45	[a] Bacthecal [DZ]	[a] Lioresal Intrathecal [NV]

baclofen 10 mg/5 mL intrathecal injection, 10 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11128Q	1	..	..	1293.45	[a] Sintetica Baclofen Intrathecal [BZ]

DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

IBANDRONATE

Authority required

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

ibandronate 6 mg/6 mL injection, 6 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9619G	1	11	..	344.41	Bondronat [RO]

PAMIDRONATE DISODIUM

Authority required

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

pamidronate disodium 60 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6288Y	1	2	..	66.41	Pamisol [PF]

pamidronate disodium 15 mg/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6286W	4	2	..	*66.39	Pamisol [PF]

pamidronate disodium 30 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6287X	2	2	..	*66.41	Pamisol [PF]

PAMIDRONATE DISODIUM

Authority required

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

Authority required

Multiple myeloma

Authority required

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

pamidronate disodium 90 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
6289B	1	11	..	94.04	Pamisol [PF]

▪ ZOLEDRONIC ACID

Note Pharmaceutical benefits that have the form zoledronic acid 4 mg/100 mL injection and pharmaceutical benefits that have the form zoledronic acid 4 mg/5 mL injection are equivalent for the purposes of substitution.

Authority required
Multiple myeloma
Authority required
Bone metastases
Clinical criteria:
- The condition must be due to breast cancer.

Authority required
Bone metastases
Clinical criteria:
- The condition must be due to castration-resistant prostate cancer.

Authority required
Hypercalcaemia of malignancy
Clinical criteria:
- Patient must have a malignancy refractory to anti-neoplastic therapy.

zoledronic acid 4 mg/100 mL injection, 100 mL bag

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10542W	1	11	..	262.29	[a] DBL Zoledronic Acid [PF]

zoledronic acid 4 mg/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6371H	1	11	..	262.29	[a] APO-Zoledronic Acid [TX] [a] Zometa [NV]	[a] DBL Zoledronic Acid [PF]

zoledronic acid 4 mg/100 mL injection, 100 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10554L	1	11	..	262.29	[a] Zometa [NV]

▪ NERVOUS SYSTEM

▪ ANTI-PARKINSON DRUGS

DOPAMINERGIC AGENTS

Dopa and dopa derivatives

▪ LEVODOPA + CARBIDOPA ANHYDROUS

Note Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.

Authority required
Advanced Parkinson disease
Clinical criteria:
- Patient must have severe disabling motor fluctuations not adequately controlled by oral therapy, **AND**
- The treatment must be commenced in a hospital-based movement disorder clinic.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL intestinal gel, 7 x 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9744W	8	5	..	*11583.15	Duodopa [VE]

Dopamine agonists

▪ APOMORPHINE

Authority required
Parkinson disease
Clinical criteria:
- Patient must have experienced severely disabling motor fluctuations which have not responded to other therapy.

apomorphine hydrochloride hemihydrate 50 mg/5 mL injection, 5 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9640J	36	5	..	*8215.15	Movapo [TD]

apomorphine hydrochloride hemihydrate 100 mg/20 mL injection, 5 x 20 mL vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11083H	18	5	..	*7599.91	Apomine Solution for Infusion [PF]

apomorphine hydrochloride hemihydrate 20 mg/2 mL injection, 5 x 2 mL ampoules

9607P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	72	5	..	*6576.43	Movapo [TD]

apomorphine hydrochloride hemihydrate 50 mg/10 mL injection, 5 x 10 mL syringes

10971K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	36	5	..	*8215.15	Movapo PFS [TD]

▪ PSYCHOLEPTICS

ANTIPSYCHOTICS

Diazepines, oxazepines, thiazepines and oxepines

▪ CLOZAPINE

Note Patients receiving clozapine under the PBS listing must be registered in the clozapine patient monitoring program relevant for the brand of clozapine being prescribed and dispensed: Novartis Clozaril Patient Monitoring System (eCPMS) or Hospira Clopineconnect.

Authority required

Schizophrenia

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a psychiatrist or in consultation with the psychiatrist affiliated with the hospital or specialised unit managing the patient.

Clinical criteria:

- Patient must be non-responsive to other neuroleptic agents; OR
- Patient must be intolerant of other neuroleptic agents.

Patients must complete at least 18 weeks of initial treatment under this restriction before being able to qualify for treatment under the continuing restriction.

The name of the consulting psychiatrist should be included in the patient's medical records.

A medical practitioner should request a quantity sufficient for up to one month's supply. Up to 5 repeats will be authorised.

clozapine 200 mg tablet, 100

6418T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*511.31	Clopine 200 [PF]

clozapine 25 mg tablet, 100

6101D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*75.79	[a] Clopine 25 [PF]	[a] Clozaril 25 [GO]

clozapine 100 mg tablet, 100

6102E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*259.23	[a] Clopine 100 [PF]	[a] Clozaril 100 [GO]

clozapine 50 mg/mL oral liquid, 100 mL

9632Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	147.55	Clopine Suspension [PF]

clozapine 50 mg tablet, 100

6417R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*141.61	Clopine 50 [PF]

▪ RESPIRATORY SYSTEM

▪ DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Other systemic drugs for obstructive airway diseases

▪ MEPOLIZUMAB

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ, please contact GlaxoSmithKline Medical Information on 1800 033 109.

Note It is recommended that an application for continuing treatment is submitted at the time of the 26 to 30 week assessment, to ensure continuity of treatment for those patients who meet the continuation criteria for PBS-subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE EOSINOPHILIC ASTHMA
Patients are eligible to commence a 'mepolizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to mepolizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised mepolizumab therapy before they are eligible to commence the next mepolizumab treatment cycle, or if eligible, an 'omalizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised mepolizumab is stopped to the date of the first application for initial treatment with mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised mepolizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised mepolizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with mepolizumab following a break in PBS-subsidised therapy of more than 6 months; or
iii) A patient has received prior PBS-subsidised omalizumab and wishes to commence treatment with mepolizumab after a treatment break of 6 months.
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 32 weeks of therapy for mepolizumab.
(b) Grandfather patients:
For patients who commenced treatment with mepolizumab for uncontrolled severe eosinophilic asthma prior to 1 January 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with mepolizumab will be authorised under this criterion. Approval will be based on the criteria included in the relevant restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with mepolizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with mepolizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with mepolizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing mepolizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted with the Initial authority application for mepolizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent mepolizumab treatment cycle, or an initial omalizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must be under the care of the same physician for at least 12 months, **AND**

- Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 1 or more occasions in the previous 12 months, **AND**
- Patient must have blood eosinophil count greater than or equal to 300 cells per microlitre in the last 6 weeks, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, AND

(b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) assessment of the patient must be made at time of application for treatment (to establish baseline score) and again around 26 to 30 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment at around 26 to 30 weeks, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab or omalizumab within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request 7 repeats to provide for an initial course of mepolizumab sufficient for 32 weeks of therapy.

Mepolizumab and omalizumab may not be used concurrently or within 6 months of each other. A patient is required to have ceased treatment with omalizumab for 6 months prior to initiating treatment with mepolizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Initial PBS Authority Application - Supporting Information Form,

which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) a copy of the eosinophil pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

mepolizumab 100 mg injection, 1 vial

11003D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	7	..	1685.15	Nucala [GK]

▪ MEPOLIZUMAB

Note For copies of the ACQ, please contact GlaxoSmithKline Medical Information on 1800 033 109.

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE EOSINOPHILIC ASTHMA

Patients are eligible to commence a 'mepolizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.

Once a patient has either failed to achieve or maintain a response to mepolizumab, they are deemed to have completed a

treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised mepolizumab therapy before they are eligible to commence the next mepolizumab treatment cycle, or if eligible, an 'omalizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised mepolizumab is stopped to the date of the first application for initial treatment with mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised mepolizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised mepolizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with mepolizumab following a break in PBS-subsidised therapy of more than 6 months; or
iii) A patient has received prior PBS-subsidised omalizumab and wishes to commence treatment with mepolizumab after a treatment break of 6 months.
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 32 weeks of therapy for mepolizumab.
(b) Grandfather patients:
For patients who commenced treatment with mepolizumab for uncontrolled severe eosinophilic asthma prior to 1 January 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with mepolizumab will be authorised under this criterion. Approval will be based on the criteria included in the relevant restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with mepolizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with mepolizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with mepolizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing mepolizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted with the Initial authority application for mepolizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent mepolizumab treatment cycle, or an initial omalizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have demonstrated or sustained an adequate response to PBS-subsidised treatment with this drug, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

An adequate response to mepolizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline,

OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline.

All applications for continuing treatment with mepolizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, and the assessment of oral corticosteroid dose, must be made at around 26 to 30weeks after the first dose of PBS-subsidised mepolizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with mepolizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course,

to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of repeats to provide for a continuing course of mepolizumab sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Continuing PBS Authority Application - Supporting Information Form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note It is recommended that second and subsequent applications for continuing treatment are submitted at the time of an 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criteria for PBS-subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Initial treatment - grandfather patients

Clinical criteria:

- Patient must have received non-PBS treatment with this drug for this condition prior to 1 January 2017, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have had, prior to commencement of mepolizumab, a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) Forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or(ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or(iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have had blood eosinophil count greater than or equal to 300 cells per microlitre prior to commencement of mepolizumab, **AND**
- Patient must have had a duration of asthma of at least 1 year prior to commencement of mepolizumab, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy prior to mepolizumab therapy despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have demonstrated an adequate response to treatment with mepolizumab, **AND**
- The treatment must not be used in combination with omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

A review of the patient's records should be conducted to extract pre- and post-mepolizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Parameters to establish response are: (i) a reduction in Asthma Control Questionnaire (ACQ-5) score of at least 0.5; and/or(ii) maintenance oral corticosteroid dose reduced by at least 25% from baseline.

The assessment of the patient's response to the initial PBS subsidised course of treatment must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for

continuing therapy to be processed. The same parameters used to establish response to non-PBS-subsidised therapy with mepolizumab should be used for the assessment.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

Patients will be eligible to receive continuing courses of mepolizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab or omalizumab within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for a continuing course of mepolizumab sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Grandfather PBS Authority Application - Supporting Information Form, which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of pre- and post-mepolizumab data on symptoms, quality of life, medication doses, severe exacerbation/s and hospitalisations, and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) a copy of the pre-mepolizumab eosinophil pathology report.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

mepolizumab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11014Q	1	5	..	1685.15	Nucala [GK]

▪ OMALIZUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

Clinical criteria:

- The condition must be based on both physical examination and patient history (to exclude any factors that may be triggering the urticaria), **AND**

- Patient must have experienced itch and hives that persist on a daily basis for at least 6 weeks despite treatment with H1 antihistamines, **AND**
- Patient must have failed to achieve an adequate response after a minimum of 2 weeks treatment with a standard therapy, **AND**
- Patient must not receive more than 12 weeks of treatment under this restriction.

A standard therapy is defined as a combination of therapies that includes H1 antihistamines at maximally tolerated doses in accordance with clinical guidelines, and one of the following:

1) a H2 receptor antagonist (150 mg twice per day); or

2) a leukotriene receptor antagonist (LTRA) (10 mg per day); or

3) doxepin (up to 25 mg three times a day)

If the requirement for treatment with H1 antihistamines and a H2 receptor antagonist, or a leukotriene receptor antagonist or doxepin cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

A failure to achieve an adequate response to standard therapy is defined as a current Urticaria Activity Score 7 (UAS7) score of equal to or greater than 28 with an itch score of greater than 8, as assessed while still on standard therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Spontaneous Urticaria Omalizumab Initial PBS Authority Application - Supporting Information Form which must include:

(i) demonstration of failure to achieve an adequate response to standard therapy; and

(ii) drug names and doses of standard therapies that the patient has failed; and

(iii) a signed patient acknowledgment that cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

omalizumab 150 mg/mL injection, 1 mL syringe

11175E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	2	..	*859.95	Xolair [NV]

▪ OMALIZUMAB

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

Clinical criteria:

- Patient must have demonstrated a response to the most recent PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not receive more than 24 weeks per authorised course of treatment under this restriction.

Note A proportion of patients respond to 150 mg 4-weekly so where a substantial improvement has been obtained with a 300 mg dose it is reasonable to back-titrate dose after initial treatment.

Note Cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have received non-PBS subsidised treatment with this drug for this condition prior to 1 September 2017, **AND**
- Patient must have documented history of itch and hives that persisted on a daily basis for at least 6 weeks despite treatment with H1 antihistamines prior to commencing non-PBS subsidised treatment with this drug for this condition, **AND**
- Patient must have documented history of failure to achieve an adequate response after a minimum of 2 weeks treatment with a standard therapy prior to commencing non-PBS subsidised treatment with this drug for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

A standard therapy is defined as a combination of therapies that includes H1 antihistamines at maximally tolerated doses in accordance with clinical guidelines, and one of the following:

1) a H2 receptor antagonist (150 mg twice per day); or

2) a leukotriene receptor antagonist (LTRA) (10 mg per day); or

3) doxepin (up to 25 mg three times a day)

If the requirement for treatment with H1 antihistamines and a H2 receptor antagonist, or a leukotriene receptor antagonist or doxepin cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

A failure to achieve an adequate response to standard therapy is defined as a current Urticaria Activity Score 7 (UAS7) score of equal to or greater than 28 with an itch score of greater than 8, as assessed while still on standard therapy.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Spontaneous Urticaria Omalizumab Initial Grandfather PBS Authority Application - Supporting Information Form which must include:

(i) demonstration of failure to achieve an adequate response to standard therapy; and

(ii) drug names and doses of standard therapies that the patient has failed; and

(iii) a signed patient acknowledgment that cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

omalizumab 150 mg/mL injection, 1 mL syringe

11163M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*859.95	Xolair [NV]

▪ OMALIZUMAB

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a diagnosis of asthma confirmed and documented by a paediatric respiratory physician, clinical immunologist, or allergist; or paediatrician or general physician experienced in the management of patients with severe asthma in consultation with a respiratory physician, defined by the following standard clinical features: forced expiratory volume (FEV1) reversibility or airway hyperresponsiveness or peak expiratory flow (PEF) variability, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or an in vitro measure of specific IgE, **AND**
- Patient must have total serum human immunoglobulin E greater than or equal to 30 IU/mL, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 6 to less than 12 years.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must be under the care of the same physician for at least 6 months.

Optimised asthma therapy includes:

(i) Adherence to optimal inhaled therapy, including high dose inhaled corticosteroid (ICS) and long-acting beta-2 agonist (LABA) therapy for at least six months. If LABA therapy is contraindicated, not tolerated or not effective, montelukast, cromoglycate or nedocromil may be used as an alternative; AND

(ii) treatment with at least 2 courses of oral or IV corticosteroids (daily or alternate day maintenance treatment courses, or 3-5 day exacerbation treatment courses), in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications (including those specified in the relevant TGA-approved Product Information) and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The initial IgE assessment must be no more than 12 months old at the time of application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) An Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month (for children aged 6 to 10 years it is recommended that the Interviewer Administered version - the ACQ-IA be used), AND

(b) while receiving optimised asthma therapy in the previous 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) or ACQ-IA assessment of the patient's response to this initial course of treatment, the assessment of oral corticosteroid dose, and the assessment of exacerbation rate must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab of up to 28 weeks, consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Severe Allergic Asthma Initial PBS Authority Application - Supporting Information form, which includes the following:

(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) acknowledgement signed by a parent or authorised guardian; and

(c) a copy of the IgE pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) or the Asthma Control Questionnaire interviewer administered version (ACQ-IA) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the prescriber's signature.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy.
(a) Initial treatment:
Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.
(b) Grandfather patients:
Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December

2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.

(c) Continuing treatment:

Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

(2) Baseline measurements to determine response:

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.

(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

(4) Monitoring of patients:

Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe allergic asthma, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

An adequate response to omalizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) or ACQ-IA score of at least 0.5 from baseline, OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 or ACQ-IA score from baseline, OR

(c) a reduction in the time-adjusted exacerbation rates compared to the 12 months prior to baseline.

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) or Asthma Control Questionnaire interviewer administered version (ACQ-IA) assessment of the patient's response to the prior course of treatment, the assessment of systemic corticosteroid dose, and the assessment of time-adjusted exacerbation rate must be made at around 18 to 22 weeks after the first dose of PBS-subsidised omalizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Severe Allergic Asthma Continuing PBS Authority Application - Supporting Information form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) or the Asthma Control Questionnaire interviewer administered version (ACQ-IA) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the signature of the prescriber.

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy.
(a) Initial treatment:
Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.
(b) Grandfather patients:
Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December 2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial and continuing treatment - balance of supply

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction or Grandfather treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the Initial restriction or up to 24 weeks treatment available under the Continuing or Grandfather restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment under the initial restriction or 24 weeks of treatment under the continuing or grandfather restrictions may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Private)

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 December 2016, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have had, prior to commencement of omalizumab, a diagnosis of asthma confirmed and documented by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician, defined by the following standard clinical features: forced expiratory volume (FEV1) reversibility or airway hyperresponsiveness or peak expiratory flow (PEF) variability, **AND**
- Patient must have had a duration of asthma of at least 1 year prior to commencement of omalizumab, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or an in vitro measure of specific IgE, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy prior to omalizumab therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- Patient must have demonstrated an adequate response to treatment.

Population criteria:

- Patient must be aged 6 to less than 12 years.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must be under the care of the same physician for at least 6 months.

Optimised asthma therapy includes:

(i) Adherence to optimal inhaled therapy, including high dose inhaled corticosteroid (ICS) and long-acting beta-2 agonist (LABA) therapy for at least six months. If LABA therapy is contraindicated, not tolerated or not effective, montelukast, cromoglycate or nedocromil may be used as an alternative; AND

(ii) treatment with at least 2 courses of oral or IV corticosteroids (daily or alternate day maintenance treatment courses, or 3-5 day exacerbation treatment courses), in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications (including those specified in the relevant TGA-approved Product Information) and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

A review of the patient's records should be conducted to extract pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Examples of parameters to establish response include:

(i) a reduction in Asthma Control Questionnaire (ACQ-5) or Asthma Control Questionnaire Interviewer Administered (ACQ-IA) score of at least 0.5;

(ii) maintenance oral corticosteroid dose reduced by at least 25% from baseline; and/or

(iii) a reduction in the number of hospitalisations or severe exacerbations requiring use of systemic corticosteroids, compared to the 12 months prior to commencement of omalizumab.

The assessment of the patient's response to the initial PBS subsidised course of treatment must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed. The same parameters used to establish response to non-PBS-subsidised therapy with omalizumab should be used for the assessment.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

Patients will be eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

Patients may qualify for PBS-subsidised treatment under this restriction once only.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for an initial course of omalizumab of up to 24 weeks, consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Grandfather Severe Allergic Asthma PBS Authority Application - Supporting Information Form, which includes the following:

(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and

(ii) details of pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations; and

(iii) acknowledgement signed by a parent or authorised guardian.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA

Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.

Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised omalizumab therapy.

(a) Initial treatment:

Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.

All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.

(b) Grandfather patients:

Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December 2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.

(c) Continuing treatment:

Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

(2) Baseline measurements to determine response:

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.

(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic

corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

omalizumab 150 mg/mL injection, 1 mL syringe

10968G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	433.55	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 0.5 mL syringe

10956P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	220.35	Xolair [NV]

▪ OMALIZUMAB

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must be under the care of the same physician for at least 12 months, **AND**
- Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 1 or more occasions in the previous 12 months, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or RAST, **AND**
- Patient must have total serum human immunoglobulin E greater than or equal to 30 IU/mL, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised mepolizumab.

Population criteria:

- Patient must be aged 12 years or older.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The initial IgE assessment must be no more than 12 months old at the time of application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, AND

(b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) assessment of the patient's response to this initial course of treatment, and the assessment of oral corticosteroid dose, must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab or mepolizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form,

which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) the IgE pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ and the calculation sheets please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next omalizumab treatment cycle or, if eligible, a 'mepolizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab or mepolizumab treatment is stopped to the date of the first application for initial treatment with omalizumab or mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised omalizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with omalizumab following a break in PBS-subsidised therapy of at least 6 months; or
iii) A patient has received prior PBS-subsidised mepolizumab and wishes to commence treatment with omalizumab after a treatment break of at least 6 months.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy of omalizumab.
(b) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or oral corticosteroid dose submitted with the Initial authority application for omalizumab. For patients transitioned from the paediatric to the adolescent/adult restriction, the exacerbation history may also be used to determine response. However, prescribers may provide new

baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent omalizumab treatment cycle, or an initial mepolizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - balance of supply

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe allergic asthma, **AND**
- Patient must have demonstrated or sustained an adequate response to PBS-subsidised treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised mepolizumab.

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Population criteria:

- Patient must be aged 12 years or older.

An adequate response to omalizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline, OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline, OR

(c) a reduction in the time-adjusted exacerbation rates compared to the 12 months prior to baseline (this criterion is only applicable for patients transitioned from the paediatric to the adolescent/adult restriction).

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, the assessment of oral corticosteroid dose, and the assessment of time adjusted exacerbation rate must be made at around 18 to 22 weeks after the first dose of PBS-subsidised omalizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form(s); and

(b) a completed Severe Allergic Asthma PBS Authority Application and Supporting Information Form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the signature of the prescriber; for patients transitioned from the paediatric to the adolescent/adult restrictions an exacerbation calculation sheet may be submitted.

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note For copies of the ACQ and the calculation sheets please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next omalizumab treatment cycle or, if eligible, a 'mepolizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab or mepolizumab treatment is stopped to the date of the first application for initial treatment with omalizumab or mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised omalizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with omalizumab following a break in PBS-subsidised therapy of at least 6 months; or
iii) A patient has received prior PBS-subsidised mepolizumab and wishes to commence treatment with omalizumab after a treatment break of at least 6 months.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy of omalizumab.
(b) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or oral corticosteroid dose submitted with the Initial authority application for omalizumab. For patients transitioned from the paediatric to the adolescent/adult restriction, the exacerbation history may also be used to determine response. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent omalizumab treatment cycle, or an initial mepolizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment - balance of supply

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

omalizumab 150 mg/mL injection, 1 mL syringe

10122R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	433.55	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 0.5 mL syringe

10110D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	220.35	Xolair [NV]

▪ COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Mucolytics

▪ DORNASE ALFA

Note It is highly desirable that all patients be included in the national cystic fibrosis patient database.

Authority required

Cystic fibrosis

Population criteria:

- Patient must be 5 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with dornase alfa at a dose of 2.5 mg daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required

Cystic fibrosis

Clinical criteria:

- Patient must have a severe clinical course with frequent respiratory exacerbations or chronic respiratory symptoms (including chronic or recurrent cough, wheeze or tachypnoea) requiring hospital admissions more frequently than 3 times per year; OR
- Patient must have significant bronchiectasis on chest high resolution computed tomography scan; OR
- Patient must have severe cystic fibrosis bronchiolitis with persistent wheeze non-responsive to conventional medicines; OR
- Patient must have severe physiological deficit measure by forced oscillation technique or multiple breath nitrogen washout and failure to respond to conventional therapy.

Population criteria:

- Patient must be less than 5 years of age.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Following an initial 6 months therapy, a comprehensive assessment must be undertaken and documented. Treatment with this drug should cease if there is not agreement of benefit, as there is always the possibility of harm from unnecessary use. Further reassessments must be undertaken and documented at six-monthly intervals.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have initiated treatment with dornase alfa at an age of less than 5 years, **AND**
- Patient must have undergone a comprehensive assessment which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

- Patient must be 5 years of age or older.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with this drug should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

dornase alfa 2.5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules

6120D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*2289.15	Pulmozyme [RO]

▪ MANNITOL

Note It is highly desirable that all patients be included in the national cystic fibrosis patient database.

Authority required

Cystic fibrosis

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must be intolerant or inadequately responsive to dornase alfa.

Population criteria:

- Patient must be 6 years of age or older.

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information initiation dose assessment for this drug, prior to therapy with this drug, with a negative result.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required

Cystic fibrosis

Clinical criteria:

- The treatment must be in combination with dornase alfa, **AND**
- Patient must be inadequately responsive to dornase alfa, **AND**
- Patient must have trialled hypertonic saline for this condition.

Population criteria:

- Patient must be 6 years of age or older.

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information initiation dose assessment for this drug, prior to therapy with this drug, with a negative result.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers, 1

2008Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	5	..	*1783.15	bronchitol [XA]

OTHER RESPIRATORY SYSTEM PRODUCTS

OTHER RESPIRATORY SYSTEM PRODUCTS

Other respiratory system products

IVACAFTOR

Note Special Pricing Arrangements apply.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - New patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and

(3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and

(5) the result of a FEV1 measurement performed within a month prior to the date of application, if aged from 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(6) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(7) a copy of a sweat chloride result; and

(8) height and weight measurements at the time of application; and

(9) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and

(3) the result of a FEV1 measurement performed within one month prior to the date of application, if aged 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(5) height and weight measurements at the time of application; and

(6) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

ivacaftor 150 mg tablet, 56

10175M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	22547.15	Kalydeco [VR]

▪ IVACAFTOR

Note Special Pricing Arrangements apply.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - New patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and

(3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and

(5) the result of a FEV1 measurement performed within a month prior to the date of application, if aged from 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(6) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(7) a copy of a sweat chloride result; and

(8) height and weight measurements at the time of application; and

(9) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and

(3) the result of a FEV1 measurement performed within one month prior to the date of application, if aged 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(5) height and weight measurements at the time of application; and

(6) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have received treatment with ivacaftor for this condition prior to 1 May 2017, **AND**
- Patient must have received treatment with ivacaftor within the last 6 months at the time of application, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be 2 to 5 years of age.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Application Supporting Information Form; and

(3) an acknowledgement signed by a parent, or authorised guardian if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene performed prior to commencing treatment with ivacaftor; and

(5) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(6) a copy of sweat chloride result performed prior to commencing treatment with ivacaftor for this condition; and
(7) height and weight measurements at the time of application; and
(8) height and weight measurements performed immediately prior to commencement of ivacaftor; and
(9) a baseline measurement of number of days of CF-related hospitalisation (including hospital-in-the home) in the 12 months prior to commencement of ivacaftor; and
(10) a measurement of the number of days of CF-related hospitalisation (including hospital-in the home) in the 6 months prior to the date of application; and
(11) dates of prior ivacaftor therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ivacaftor 75 mg granules, 4 x 14 sachets

11109Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	22547.15	Kalydeco [VR]

ivacaftor 50 mg granules, 4 x 14 sachets

11097C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	22547.15	Kalydeco [VR]

▪ VARIOUS

▪ ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Iron chelating agents

▪ DEFERASIROX

Note Special Pricing Arrangements apply.

Authority required
Chronic iron overload
Clinical criteria:
- Patient must have a disorder of erythropoiesis.

deferasirox 125 mg dispersible tablet, 28

6499C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	6	5	..	*1378.57	Exjade [NV]

deferasirox 500 mg dispersible tablet, 28

9600G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	6	5	..	*5372.71	Exjade [NV]

deferasirox 250 mg dispersible tablet, 28

6500D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	6	5	..	*2709.91	Exjade [NV]

▪ DEFERIPRONE

Authority required
Iron overload
Clinical criteria:
- Patient must have thalassaemia major, **AND**
- Patient must be unable to take desferrioxamine therapy.

Authority required
Iron overload
Clinical criteria:
- Patient must have thalassaemia major, **AND**
- Patient must be one in whom desferrioxamine therapy has proven ineffective.

deferiprone 500 mg tablet, 100

6416Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	6	5	..	*2615.35	Ferriprox [TX]

deferiprone 100 mg/mL oral liquid, 250 mL

9638G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	5	5	..	*1117.25	Ferriprox [TX]

▪ DESFERRIOXAMINE

Authority required

Disorders of erythropoiesis

Clinical criteria:

- The condition must be associated with treatment-related chronic iron overload.

desferrioxamine mesilate 500 mg injection, 10 vials

6113R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	40	5	..	*4301.95	Hospira Pty Limited [PF]

desferrioxamine mesilate 2 g injection, 1 vial

6270B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	60	5	..	*1915.75	Hospira Pty Limited [PF]

Drugs for treatment of hyperkalemia and hyperphosphatemia

▪ LANTHANUM

Authority required

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

9637F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*886.49	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

9636E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*788.23	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

9635D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*524.41	Fosrenol [ZI]

▪ SEVELAMER

Authority required

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

sevelamer hydrochloride 800 mg tablet, 180

9620H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*619.71	Renagel [GZ]

▪ SUCROFERRIC OXYHYDROXIDE

Authority required

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

iron (as sucroferric oxyhydroxide) 500 mg tablet: chewable, 90

10230K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*790.75	Velphoro [FN]

Highly Specialised Drugs Program (Public Hospital)

HSD (Public)

BLOOD AND BLOOD FORMING ORGANS 998

ANTIHEMORRHAGICS 998
VITAMIN K AND OTHER HEMOSTATICS 998
ANTIANEMIC PREPARATIONS 1003
OTHER ANTIANEMIC PREPARATIONS 1003

CARDIOVASCULAR SYSTEM 1007

ANTIHYPERTENSIVES 1007
OTHER ANTIHYPERTENSIVES 1007

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 1058

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES 1058
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES 1058
HYPOTHALAMIC HORMONES 1060

ANTIINFECTIVES FOR SYSTEMIC USE 1065

ANTIBACTERIALS FOR SYSTEMIC USE 1065
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS 1065
ANTIMYCOBACTERIALS 1065
DRUGS FOR TREATMENT OF TUBERCULOSIS 1065
ANTIVIRALS FOR SYSTEMIC USE 1065
DIRECT ACTING ANTIVIRALS 1065

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 1071

ANTINEOPLASTIC AGENTS 1071
ANTIMETABOLITES 1071
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES 1073
OTHER ANTINEOPLASTIC AGENTS 1073
IMMUNOSTIMULANTS 1074
IMMUNOSTIMULANTS 1074
IMMUNOSUPPRESSANTS 1085
IMMUNOSUPPRESSANTS 1085

MUSCULO-SKELETAL SYSTEM 1203

MUSCLE RELAXANTS 1203
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS 1203
DRUGS FOR TREATMENT OF BONE DISEASES 1204

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION 1204

NERVOUS SYSTEM 1206

ANTI-PARKINSON DRUGS 1206
DOPAMINERGIC AGENTS 1206
PSYCHOLEPTICS 1206
ANTIPSYCHOTICS 1206

RESPIRATORY SYSTEM 1207

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 1207
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES 1207
COUGH AND COLD PREPARATIONS 1224
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS 1224
OTHER RESPIRATORY SYSTEM PRODUCTS 1225
OTHER RESPIRATORY SYSTEM PRODUCTS 1225

VARIOUS 1230

ALL OTHER THERAPEUTIC PRODUCTS 1230
ALL OTHER THERAPEUTIC PRODUCTS 1230

HSD (Public)

BLOOD AND BLOOD FORMING ORGANS

ANTIHEMORRHAGICS

VITAMIN K AND OTHER HEMOSTATICS

Other systemic hemostatics

ELTROMBOPAG

Note No applications for increased repeats will be authorised.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 1 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy following the splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy following the splenectomy, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 2 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must not have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy, **AND**
- Patient must be unsuitable for splenectomy due to medical reasons, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

HSD (Public)

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

Treatment Phase: First Continuing treatment or Re-initiation of interrupted treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised initial treatment with this drug for this condition, **AND**
- Patient must have demonstrated a sustained platelet response to PBS-subsidised treatment with this drug for this condition under the Initial treatment restriction, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised treatment with this drug,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart; OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the First continuing PBS-subsidised treatment or Re-initiation of interrupted PBS-subsidised treatment must be made in writing and must include:

(1) a completed authority prescription form, and

(2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form , and

(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The platelet count must be no more than one month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe thrombocytopenia

HSD (Public)

Treatment Phase: Second or subsequent Continuing treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a continuing response to treatment with this drug, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purpose of this restriction, a continuing response to treatment with drug is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with this drug

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

The platelet count must be no more than one month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone

Note Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Note Authority applications for second and subsequent continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial 1, Initial 2, First Continuing treatment or Re-initiation of interrupted treatment, and Second and Subsequent Continuing treatment - balance of supply

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition, **AND**
- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the First Continuing treatment or Re-initiation of interrupted treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Second and subsequent Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

eltrombopag 25 mg tablet, 28

5825N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	1436.40	Revolade [NV]

eltrombopag 50 mg tablet, 28

5826P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	2872.80	Revolade [NV]

▪ ROMIPLOSTIM

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 1 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy following the splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy following the splenectomy, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be requested by telephone. The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial treatment 2 - New patient

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must not have had a splenectomy, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks, **AND**
- Patient must have failed to acheive an adequate response to, or be intolerant to, immunoglobulin therapy, **AND**
- Patient must be unsuitable for splenectomy due to medical reasons, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of initial application;

(a) a platelet count of less than or equal to 20,000 million per L; OR

(b) a platelet count of 20,000 million to 30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be requested by telephone. The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

HSD (Public)

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form,

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

HSD (Public)

Authority required

Severe thrombocytopenia

Treatment Phase: First Continuing treatment or Re-initiation of interrupted treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- Patient must have previously received PBS-subsidised initial treatment with this drug for this condition, **AND**
- Patient must have demonstrated a sustained platelet response to PBS-subsidised treatment with this drug for this condition under the Initial treatment restriction, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised treatment with this drug,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

Applications for the First continuing PBS-subsidised treatment or Re-initiation of interrupted PBS-subsidised treatment must be made in writing and must include:

(1) a completed authority prescription form, and

(2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form , and

(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The platelet count must be no more than one month old at the time of application.

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Second or Subsequent Continuing treatment

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have demonstrated a continuing response to treatment with this drug, **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition.

Population criteria:

- Patient must be an adult.

For the purpose of this restriction, a continuing response to treatment with drug is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with this drug

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

The platelet count must be no more than one month old at the time of application.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses higher than 10 micrograms/kg/week

Authority applications for second and subsequent periods of continuing therapy may be made by telephone

Note Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Note Authority applications for second and subsequent continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Patients will be able to trial either eltrombopag or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Note Any queries concerning the arrangements to prescribe this drug may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe this drug should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe thrombocytopenia

Treatment Phase: Initial 1, Initial 2, First Continuing treatment or Re-initiation of interrupted treatment, and Second and Subsequent Continuing treatment - balance of supply

Clinical criteria:

- The condition must be severe chronic immune (idiopathic) thrombocytopenic purpura (ITP), **AND**
- The treatment must be the sole PBS-subsidised thrombopoietin receptor agonist (TRA) for this condition, **AND**
- Patient must have received insufficient therapy with this drug for this condition under the Initial 1 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Initial 2 restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the First Continuing treatment or Re-initiation of interrupted treatment restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug for this condition under the Second and subsequent Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note No applications for increased repeats will be authorised.

romiplostim 500 microgram injection, 1 vial

9698K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1857.25	Nplate [AN]

romiplostim 250 microgram injection, 1 vial

9696H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	928.63	Nplate [AN]

ANTIANEMIC PREPARATIONS

OTHER ANTIANEMIC PREPARATIONS

Other antianemic preparations

▪ DARBEPOETIN ALFA

Authority required (STREAMLINED)

6294

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

darbepoetin alfa 150 microgram/0.3 mL injection, 0.3 mL syringe

5650J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*3709.28	Aranesp SureClick [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 0.5 mL syringe

5649H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*2489.44	Aranesp SureClick [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5642Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1535.82	Aranesp [AN]

darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5641X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1307.94	Aranesp [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5640W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1057.92	Aranesp [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5643B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3709.28	Aranesp [AN]

darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5639T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*871.58	Aranesp [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5651K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2489.48	Aranesp [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 0.3 mL syringe

5647F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*1535.84	Aranesp SureClick [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 0.5 mL syringe

5645D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*637.12	Aranesp SureClick [AN]

darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5637Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*338.28	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5644C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2021.60	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 0.4 mL syringe

5648G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*2021.60	Aranesp SureClick [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 0.4 mL syringe

5646E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	8	5	..	*1057.92	Aranesp SureClick [AN]

HSD (Public)

darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5638R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*637.08	Aranesp [AN]

▪ EPOETIN ALFA

Authority required (STREAMLINED)

6294

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin alfa 10 000 units/mL injection, 6 x 1 mL syringes

5722E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1871.78	Eprex 10000 [JC]

epoetin alfa 20 000 units/0.5 mL injection, 6 x 0.5 mL syringes

5713Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3682.20	Eprex 20,000 [JC]

epoetin alfa 6000 units/0.6 mL injection, 6 x 0.6 mL syringes

5716W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1192.38	Eprex 6000 [JC]

epoetin alfa 4000 units/0.4 mL injection, 6 x 0.4 mL syringes

5721D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*806.84	Eprex 4000 [JC]

epoetin alfa 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

5720C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*633.56	Eprex 3000 [JC]

epoetin alfa 2000 units/0.5 mL injection, 6 x 0.5 mL syringes

5719B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*490.96	Eprex 2000 [JC]

epoetin alfa 1000 units/0.5 mL injection, 6 x 0.5 mL syringes

5714R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*265.34	Eprex 1000 [JC]

epoetin alfa 5000 units/0.5 mL injection, 6 x 0.5 mL syringes

5715T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1004.48	Eprex 5000 [JC]

epoetin alfa 40 000 units/mL injection, 1 mL syringe

5718Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1191.30	Eprex 40,000 [JC]

epoetin alfa 8000 units/0.8 mL injection, 6 x 0.8 mL syringes

5717X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1546.52	Eprex 8000 [JC]

▪ EPOETIN BETA

Authority required (STREAMLINED)

6294

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin beta 10 000 units/0.6 mL injection, 6 x 0.6 mL syringes

5729M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1871.78	NeoRecormon [RO]

epoetin beta 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

5725H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*633.56	NeoRecormon [RO]

epoetin beta 6000 units/0.3 mL injection, 6 x 0.3 mL syringes

5728L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1192.38	NeoRecormon [RO]

epoetin beta 2000 units/0.3 mL injection, 6 x 0.3 mL syringes

5724G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*490.96	NeoRecormon [RO]

epoetin beta 5000 units/0.3 mL injection, 6 x 0.3 mL syringes

5727K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1004.50	NeoRecormon [RO]

epoetin beta 4000 units/0.3 mL injection, 6 x 0.3 mL syringes

5726J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*806.84	NeoRecormon [RO]

▪ EPOETIN LAMBDA

Authority required (STREAMLINED)

6294

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

epoetin lambda 8000 units/0.8 mL injection, 6 x 0.8 mL syringes

9594Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1465.12	Novicrit [SZ]

epoetin lambda 6000 units/0.6 mL injection, 6 x 0.6 mL syringes

9591T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1129.62	Novicrit [SZ]

epoetin lambda 1000 units/0.5 mL injection, 6 x 0.5 mL syringes

9668W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*251.38	Novicrit [SZ]

epoetin lambda 5000 units/0.5 mL injection, 6 x 0.5 mL syringes

9589Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*951.62	Novicrit [SZ]

epoetin lambda 2000 units/mL injection, 6 x 1 mL syringes

9669X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*465.12	Novicrit [SZ]

epoetin lambda 10 000 units/mL injection, 6 x 1 mL syringes

9596C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1773.28	Novicrit [SZ]

epoetin lambda 4000 units/0.4 mL injection, 6 x 0.4 mL syringes

9587N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*764.38	Novicrit [SZ]

epoetin lambda 3000 units/0.3 mL injection, 6 x 0.3 mL syringes

9670Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*600.22	Novicrit [SZ]

HSD (Public)

▪ METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA

Authority required (STREAMLINED)

6294

Anaemia associated with intrinsic renal disease

Clinical criteria:

- Patient must require transfusion, **AND**
- Patient must have a haemoglobin level of less than 100 g per L, **AND**
- Patient must have intrinsic renal disease, as assessed by a nephrologist.

methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe

5800G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3160.20	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5798E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1274.56	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5797D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1100.88	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5794Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*350.72	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5795B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*584.54	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5796C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*851.22	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5799F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1828.08	Mircera [RO]

▪ CARDIOVASCULAR SYSTEM

▪ ANTIHYPERTENSIVES

OTHER ANTIHYPERTENSIVES

Antihypertensives for pulmonary arterial hypertension

▪ AMBRISENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

HSD (Public)

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

HSD (Public)

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

ambrisentan 10 mg tablet, 30

5608E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2732.65	Volibris [GK]

ambrisentan 5 mg tablet, 30

5607D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2732.65	Volibris [GK]

▪ BOSENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services

HSD (Public)

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

HSD (Public)

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice. The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH

agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

HSD (Public)

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

bosentan 125 mg tablet, 60

5619R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	2295.43	[a] Bosentan APOTEX [TX]	[a] BOSENTAN-DRLA [RZ]
				[a] Bosentan GH [GQ]	[a] Bosentan Mylan [AF]

[a] Bosentan RBX [RA] [a] Bosentan Sandoz [SZ]
[a] BOSLEER [RW] [a] Tracleer [AT]

▪ BOSENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

HSD (Public)

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

HSD (Public)

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

HSD (Public)

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.
The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs

HSD (Public)

Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Cessation of treatment (all patients)

Clinical criteria:

- Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**
- Patient must have not responded to prior PBS-subsidised therapy with this agent, **AND**
- The treatment must be for the purpose of gradual dose reduction prior to ceasing therapy, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment. Treatment beyond 1 month will not be approved.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

bosentan 62.5 mg tablet, 60

5618Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	2295.43	[a] Bosentan APOTEX [TX] [a] Bosentan Mylan [AF] [a] Bosentan Sandoz [SZ] [a] Tracleer [AT]	[a] BOSENTAN-DRLA [RZ] [a] Bosentan RBX [RA] [a] BOSLEER [RW]

▪ EPOPROSTENOL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

HSD (Public)

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and

(4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

HSD (Public)

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients) or Initial 2 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

HSD (Public)

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

HSD (Public)

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

epoprostenol 1.5 mg injection [1 vial] (&) inert substance diluent [2 x 50 mL vials], 1 pack

11065J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	66.55	Flolan [GK]

epoprostenol 500 microgram injection, 1 vial

10130E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	33.28	Veletri [AT]

epoprostenol 1.5 mg injection, 1 vial

10117L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	66.55	Veletri [AT]

epoprostenol 500 microgram injection [1 vial] (&) inert substance diluent [2 x 50 mL vials], 1 pack

11090Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	33.28	Flolan [GK]

▪ ILOPROST

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with this agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III drug-induced PAH, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III drug-induced PAH and a mean right atrial pressure greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III drug-induced PAH with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class IV drug-induced PAH, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

HSD (Public)

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or drug-induced PAH and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and

(4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

HSD (Public)

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note Special Pricing Arrangements apply.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

HSD (Public)

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

HSD (Public)

iloprost 20 microgram/2 mL inhalation solution, 30 x 2 mL ampoules

5751Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	408.88	Ventavis [BN]

▪ MACITENTAN

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;
(2) RHC composite assessment plus 6MWT;
(3) RHC composite assessment only.
In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:
(1) ECHO composite assessment plus 6MWT;
(2) ECHO composite assessment only.
Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.
The test results provided must not be more than 2 months old at the time of application.
Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.
Response to prior vasodilator treatment is defined as follows:
For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.
A maximum of 5 repeats may be requested.
The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.
Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.
The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.
PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)
Treatment Phase: Initial 2 (new patients)
Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:
(1) a completed authority prescription form; and

HSD (Public)

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

A maximum of 5 repeats will be authorised.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**

- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

macitentan 10 mg tablet, 30

10136L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	2876.47	Opsumit [AT]

▪ RIOCIGUAT

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 1 month following cessation of therapy, as recommended by the TGA-approved Product Information.

Note Special Pricing Arrangements apply.

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have WHO Functional Class II, III or IV CTEPH, **AND**
- The condition must be inoperable by pulmonary endarterectomy; OR
- The condition must be recurrent or persistent following pulmonary endarterectomy, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

CTEPH that is inoperable by pulmonary endarterectomy is defined as follows:

- Right heart catheterisation (RHC) demonstrating pulmonary vascular resistance (PVR) of greater than 300 dyn*sec*cm^{-5} measured at least 90 days after start of full anticoagulation; and
- A mean pulmonary artery pressure (PAPmean) of greater than 25 mmHg at least 90 days after start of full anticoagulation.

CTEPH that is recurrent or persistent subsequent to pulmonary endarterectomy is defined as follows:

- RHC demonstrating a PVR of greater than 300 dyn*sec*cm^{-5} measured at least 180 days following pulmonary endarterectomy.

Where a RHC cannot be performed due to right ventricular dysfunction, an echocardiogram demonstrating the dysfunction must be provided at the time of application.

Applications for authorisation must be in writing and must include:(1) completed authority prescription forms sufficient for dose titration; and(2) a completed CTEPH PBS Initial Authority Application - Supporting Information form which includes results from the 3 tests below, to establish baseline measurements, where available:(i) RHC composite assessment, and(ii) ECHO composite assessment, and(iii) 6 Minute Walk Test (6MWT); and(3) a signed patient acknowledgment form; and(4) confirmation of evidence of inoperable CTEPH including results of a pulmonary vascular resistance (PVR), a mean pulmonary artery pressure (PAPmean) and the starting date of full anticoagulation; or(5) confirmation of evidence of recurrent or persistent CTEPH including result of PVR and the date that pulmonary endarterectomy was performed; or(6) confirmation of an echocardiogram demonstrating right ventricular dysfunction.

Where it is not possible to perform all 3 tests above on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT;(3) RHC composite assessment only.

In circumstance where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) ECHO composite assessment plus 6MWT;(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Prescriptions for dose titration must provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, The quantity approved must be based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 3 repeats.

The assessment of the patient's response to the initial 20-week course of treatment should be made following the preceding 16 weeks of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must demonstrate stable or responding disease, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be in writing and must include:(1) a completed authority prescription form; and(2) a completed CTEPH PBS Continuing Authority Application - Supporting Information form which includes results from the three tests below, where available:(i) RHC composite assessment; and(ii) ECHO composite assessment; and(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to this drug is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease.

The assessment of the patient's response to the continuing 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

The maximum quantity per prescription must be based on the dosage recommendations in the TGA-approved Product Information and be limited to provide sufficient supply for 1 month of treatment.

A maximum of 5 repeats will be authorised.

Applications for continuing treatment with this drug should be made two weeks prior to the completion of the 6-month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate disease stability or improvement to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Grandfathered patients

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 January 2017, **AND**
- Patient must have a documented history of WHO Functional Class II, III or IV CTEPH, **AND**
- The condition must be inoperable by pulmonary endarterectomy; OR
- The condition must be recurrent or persistent following pulmonary endarterectomy.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Clinical criteria:

- The treatment must be the sole PBS-subsidised agent for this condition.

Population criteria:

- Patient must be aged 18 years or older.

CTEPH that is inoperable by pulmonary endarterectomy is defined as follows:

- Right heart catheterisation (RHC) demonstrating pulmonary vascular resistance (PVR) of greater than 300 dyn*sec*cm^{-5} measured at least 90 days after start of full anticoagulation; and
- A mean pulmonary artery pressure (PAPmean) of greater than 25 mmHg at least 90 days after start of full anticoagulation.

CTEPH that is recurrent or persistent subsequent to pulmonary endarterectomy is defined as follows:

- RHC demonstrating a PVR of greater than 300 dyn*sec*cm^{-5} measured at least 180 days following pulmonary endarterectomy.

Where a RHC cannot be performed due to right ventricular dysfunction, an echocardiogram demonstrating the dysfunction must be provided at the time of application.

Applications for authorisation must be in writing and must include:(1) A completed authority prescription form; and(2) a completed CTEPH PBS Initial Authority Application - Supporting Information form which includes results from the 3 tests below, to establish baseline measurements, where available:(i) RHC composite assessment, and(ii) ECHO composite assessment, and(iii) 6 Minute Walk Test (6MWT); and(3) a signed patient acknowledgment form; and(4) confirmation of evidence of inoperable CTEPH including results of a pulmonary vascular resistance (PVR), a mean pulmonary artery pressure (PAPmean) and the starting date of full anticoagulation; or(5) confirmation of evidence of recurrent or persistent CTEPH including result of PVR and the date that pulmonary endarterectomy was performed; or(6) confirmation of an echocardiogram demonstrating right ventricular dysfunction.

Where it is not possible to perform all 3 tests above on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT;(2) RHC composite assessment only.

In circumstance where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:(1) ECHO composite assessment plus 6MWT;(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Chronic thromboembolic pulmonary hypertension (CTEPH)

Treatment Phase: Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial treatment restriction to complete a maximum of 20 weeks of treatment; OR
- Patient must have received insufficient therapy with this agent under the Continuing treatment restriction to complete a maximum of 24 weeks of treatment; OR
- Patient must have received insufficient therapy with this agent under the Grandfathering restriction to complete a maximum of 24 weeks of treatment, **AND**

HSD (Public)

- The treatment must provide no more than the balance of up to 20 or 24 weeks of treatment available under the above respective restriction, **AND**
- The treatment must be the sole PBS-subsidised agent for this condition.

Treatment criteria:

- Must be treated in a centre with expertise in the management of CTEPH.

Population criteria:

- Patient must be aged 18 years or older.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

riociguat 500 microgram tablet, 42

11001B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 2.5 mg tablet, 84

11019Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 2.5 mg tablet, 42

11002C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 1 mg tablet, 42

10976Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 2 mg tablet, 42

10984D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 500 microgram tablet, 84

10995Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1.5 mg tablet, 84

10977R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1 mg tablet, 84

11020B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 2 mg tablet, 84

11013P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1.5 mg tablet, 42

10989J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

▪ RIOCIGUAT

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 1 month following cessation of therapy, as recommended by the TGA-approved Product Information.

Note Special Pricing Arrangements apply.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR

- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension Initial PBS Authority Application - Supporting Information form which includes results from the three tests below, where available: (i) RHC composite assessment; and (ii) ECHO composite assessment; and (iii) 6 Minute Walk Test (6MWT); and (3) a signed patient acknowledgement. Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows: (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
- Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension Initial PBS Authority Application - Supporting Information form which includes results from the three tests below, where available: (i) RHC composite assessment; and (ii) ECHO composite assessment; and (iii) 6 Minute Walk Test (6MWT); and (3) a signed patient acknowledgement. Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows: (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

HSD (Public)

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include: (1) completed authority prescription forms sufficient for dose titration; and (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application. The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for prescriptions for dose titration will provide sufficient quantity for dose titrations by 0.5 mg increments at 2-week intervals to achieve up to a maximum of 2.5 mg three times daily based on the dosage recommendations for initiation of treatment in the TGA-approved Product Information. No repeats will be authorised for these prescriptions.

Approvals for subsequent authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

HSD (Public)

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

HSD (Public)

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made two weeks prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 4 (Grandfathered patients)

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must be receiving treatment with this drug at the time of application, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a documented history of a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have a documented history of right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have a documented history of failure to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows: The first written application for PBS-subsidised treatment should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements. The test results provided must not be more than 2 months old at the time of application.Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment: (1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT; (3) RHC composite assessment only. In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference: (1) ECHO composite assessment plus 6MWT; (2) ECHO composite assessment only. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approval for authority prescriptions will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 5 repeats.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note No applications for increased repeats will be authorised.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 5 (Grandfathered patients)

Clinical criteria:

- Patient must have previously received treatment with this drug for this condition prior to 1 February 2017, **AND**
- Patient must be receiving treatment with this drug at the time of application, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have a documented history of WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have a documented history of WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR
- Patient must have a documented history of WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have a documented history of WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

HSD (Public)

- Patient must have a documented history of WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows: The first written application for PBS-subsidised treatment should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements. The test results provided must not be more than 2 months old at the time of application.Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment: (1) RHC plus ECHO composite assessments;(2) RHC composite assessment plus 6MWT; (3) RHC composite assessment only. In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference: (1) ECHO composite assessment plus 6MWT; (2) ECHO composite assessment only. Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

Approval for authority prescriptions will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 5 repeats.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note No applications for increased repeats will be authorised.

riociguat 500 microgram tablet, 42

11040C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 2.5 mg tablet, 84

11024F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 2.5 mg tablet, 42

11057Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

HSD (Public)

riociguat 1 mg tablet, 42

11054T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 2 mg tablet, 42

11038Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

riociguat 500 microgram tablet, 84

11059C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1.5 mg tablet, 84

11048L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1 mg tablet, 84

11053R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 2 mg tablet, 84

11039B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3435.42	Adempas [BN]

riociguat 1.5 mg tablet, 42

11047K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	1717.71	Adempas [BN]

▪ SILDENAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

HSD (Public)

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

HSD (Public)

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**

- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

HSD (Public)

An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

sildenafil 20 mg tablet, 90

9547L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	319.72	[a] APO-Sildenafil PHT [TX] [a] Sildenafil AN PHT 20 [EA] [a] Sildenafil Sandoz PHT 20 [SZ]	[a] Revatio [PF] [a] SILDENAFIL-DRx [RZ]

HSD (Public)

▪ TADALAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**
- Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
- Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**
- Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

- Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditable PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR
- Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditable pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

HSD (Public)

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR
- Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditable PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The assessment of the patient's response to the initial 6 month course of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents: Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 8 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment. Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 8 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Caution This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or First Continuing treatment - Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
- Patient must have received insufficient therapy with this agent under the First Continuing treatment restriction to complete a maximum of six months of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
- The treatment must provide no more than the balance of up to six months treatment available under one of the above restrictions.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: First Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised initial course of treatment with this agent for this condition, **AND**
- Patient must have been assessed by a physician from a designated hospital to have achieved a response to the PBS-subsidised initial course of treatment, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

HSD (Public)

(i) RHC composite assessment; and
(ii) ECHO composite assessment; and
(iii) 6 Minute Walk Test (6MWT).
Test requirements to establish response to treatment for continuation of treatment are as follows:
The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:
(1) RHC plus ECHO composite assessments plus 6MWT;
(2) RHC plus ECHO composite assessments;
(3) RHC composite assessment plus 6MWT;
(4) ECHO composite assessment plus 6MWT;
(5) RHC composite assessment only;
(6) ECHO composite assessment only.
The results of the same tests as conducted at baseline should be provided with the written First Continuing treatment application, except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.
The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.
Response to a PAH agent is defined as follows:
For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.
The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.
A maximum of 5 repeats will be authorised.
An application for First Continuing treatment with a PAH agent should be made prior to the completion of the Initial 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.
Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.
The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.
PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Subsequent Continuing treatment

Clinical criteria:

- Patient must have received a PBS-subsidised treatment under First Continuing treatment with this agent for this condition; OR
- Patient must have previously received PBS-subsidised treatment under this criteria with this agent for this condition, **AND**
- Patient must have been assessed by a physician at a designated hospital, **AND**
- The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.
A maximum of 5 repeats will be authorised.
An application for Subsequent Continuing treatment with a PAH agents should be made prior to the completion of the First Continuing treatment course to ensure continuity of treatment.
PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.
The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, macitentan, and riociguat.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

tadalafil 20 mg tablet, 56

1308W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	796.60	Adcirca [LY]

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

Other anterior pituitary lobe hormones and analogues

PEGVISOMANT

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue.

Somatostatin analogues include octreotide, lanreotide and pasireotide

Failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide is defined as:

1) Growth hormone level greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Two completed authority prescriptions should be submitted with the initial application for this drug. One prescription should be for the loading dose of 80 mg for a quantity of 4 vials of 20 mg with no repeats. The second prescription should be for subsequent doses, starting from 10 mg daily, and allowing dose adjustments in increments of 5 mg based on serum IGF-1 levels measured every 4 to 6 weeks in order to maintain the serum IGF-1 level within the age-adjusted normal range based on the dosage recommendations in the TGA-approved Product Information.

The authority application must be made in writing and must include:

a) two completed authority prescription forms ; and

b) a completed Acromegaly Pegvisomant initial PBS Authority Application - Supporting Information Form; and

c) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and

d) a recent result of the IGF-1 level and the date of assessment ; and

e) demonstration of failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide

No increase in the maximum quantity or number of units may be authorised for the loading dose.

pegvisomant 20 mg injection [1 vial] (&) inert substance diluent [1 syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11177G	4	..	..	*557.16	Somavert [PF]

▪ PEGVISOMANT

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue.

Somatostatin analogues include octreotide, lanreotide and pasireotide

Failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide is defined as:

1) Growth hormone level greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Two completed authority prescriptions should be submitted with the initial application for this drug. One prescription should be for the loading dose of 80 mg for a quantity of 4 vials of 20 mg with no repeats. The second prescription should be for subsequent doses, starting from 10 mg daily, and allowing dose adjustments in increments of 5 mg based on serum IGF-1 levels measured every 4 to 6 weeks in order to maintain the serum IGF-1 level within the age-adjusted normal range based on the dosage recommendations in the TGA-approved Product Information.

The authority application must be made in writing and must include:

a) two completed authority prescription forms ; and

b) a completed Acromegaly Pegvisomant initial PBS Authority Application - Supporting Information Form; and

c) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and

d) a recent result of the IGF-1 level and the date of assessment ; and

e) demonstration of failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide

No increase in the maximum quantity or number of units may be authorised for the loading dose.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acromegaly

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition., **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue, **AND**
- The treatment must cease if IGF-1 is not lower after 3 months of pegvisomant treatment at the maximum tolerated dose.

Somatostatin analogues include octreotide, lanreotide and pasireotide

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

HSD (Public)

In a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of IGF-1 level taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided at the time of application.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Acromegaly

Treatment Phase: Grandfathering

Clinical criteria:

- Patient must have received non-PBS subsidised treatment with this drug for this condition prior to 1 September 2017, **AND**
- The treatment must not be given concomitantly with a PBS-subsidised somatostatin analogue, **AND**
- Patient must have had a documented age- and sex- adjusted insulin- like factor 1 (IGF-1) concentration greater than 1.3 times upper limit of normal (ULN) prior to commencing non- PBS- subsidised treatment with this drug.

Somatostatin analogues include octreotide, lanreotide and pasireotide

In a patient treated with radiotherapy, pegvisomant should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pegvisomant should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1).

Treatment must be ceased if IGF-1 level is not lower after 3 months of pegvisomant treatment at the maximum tolerated dose.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be made in writing and must include:

1. a completed authority prescription form; and
2. a completed Acromegaly Pegvisomant Grandfather PBS Authority Application - Supporting Information Form; and
3. in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy, the date and result of IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy; and
4. a recent result of the IGF-1 level and the date of assessment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pegvisomant 15 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11173C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4178.57	Somavert [PF]

pegvisomant 10 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11179J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4178.57	Somavert [PF]

pegvisomant 20 mg injection [30 vials] (&) inert substance diluent [30 syringes], 1 pack

11181L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	4178.57	Somavert [PF]

HYPOTHALAMIC HORMONES

Somatostatin and analogues

▪ LANREOTIDE

Authority required (STREAMLINED)

7042

Acromegaly

Clinical criteria:

- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**

- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (6 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

lanreotide 30 mg modified release injection [1 vial] (&) inert substance diluent [2 mL ampoule], 1 pack

5776B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1425.00	Somatuline LA [IS]

▪ LANREOTIDE

Authority required (STREAMLINED)

7025

Acromegaly

Clinical criteria:

- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Authority required (STREAMLINED)

4575

Functional carcinoid tumour

Clinical criteria:

- The condition must be causing intractable symptoms, **AND**
- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 120 mg every 28 days.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

lanreotide 120 mg/0.5 mL injection, 0.5 mL syringe

5779E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*4256.00	Somatuline Autogel [IS]

lanreotide 60 mg/0.5 mL injection, 0.5 mL syringe

5777C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2555.50	Somatuline Autogel [IS]

lanreotide 90 mg/0.5 mL injection, 0.5 mL syringe

5778D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*3401.00	Somatuline Autogel [IS]

▪ OCTREOTIDE

Authority required (STREAMLINED)

7029

Acromegaly

Clinical criteria:

- The condition must be controlled with octreotide immediate release injections, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission

Authority required (STREAMLINED)

HSD (Public)

5901
Functional carcinoid tumour
Clinical criteria:
- Patient must have achieved symptom control on octreotide immediate release injections, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.
Authority required (STREAMLINED)
5906
Vasoactive intestinal peptide secreting tumour (VIPoma)
Clinical criteria:
- Patient must have achieved symptom control on octreotide immediate release injections, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 20 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10533J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*3479.62	Sandostatin LAR [NV]

octreotide 30 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10550G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*4354.92	Sandostatin LAR [NV]

octreotide 10 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10543X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*2613.72	Sandostatin LAR [NV]

▪ OCTREOTIDE

Authority required (STREAMLINED)
7028
Acromegaly
Clinical criteria:
- The condition must be active, **AND**
- Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**
- The treatment must be after failure of other therapy including dopamine agonists; OR
- The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR
- The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**
- The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks, **AND**
- The treatment must cease if IGF1 is not lower after 3 months of treatment at a dose of 100 micrograms 3 time daily, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission
Authority required (STREAMLINED)
6390
Functional carcinoid tumour
Clinical criteria:
- The condition must be causing intractable symptoms, **AND**
- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.
Authority required (STREAMLINED)
6369
Vasoactive intestinal peptide secreting tumour (VIPoma)
Clinical criteria:
- The condition must be causing intractable symptoms, **AND**

- Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**
- Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**
- The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 50 microgram/mL injection, 5 x 1 mL ampoules

9508K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*619.02	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.05 [NV]

octreotide 500 microgram/mL injection, 5 x 1 mL ampoules

9510M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*6194.52	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.5 [NV]

octreotide 100 microgram/mL injection, 5 x 1 mL ampoules

9509L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*1236.42	[a] Hospira Pty Limited [PF] [a] Octreotide (SUN) [RA]	[a] Octreotide MaxRx [GQ] [a] Sandostatin 0.1 [NV]

HSD (Public)

▪ PASIREOTIDE

Caution Careful monitoring of patients is mandatory due to high risk of developing hyperglycaemia

Note Special Pricing Arrangements apply.

Authority required

Acromegaly

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must not have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must have a mean growth hormone (GH) level greater than 2.5 micrograms per litre, **AND**
- Patient must have an age- and sex-adjusted insulin-like growth factor 1 (IGF-1) level greater than 1.3 times the upper limit of normal (ULN), **AND**
- The treatment must be after failure to achieve biochemical control with a maximum indicated dose of either 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks; unless contraindicated or not tolerated according to the TGA approved Product Information, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

Population criteria:

- Patient must be aged 18 years or older.

If treatment with either octreotide or lanreotide is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of contraindication.

If intolerance to either octreotide or lanreotide treatment developed during the relevant period of use which is of a severity to necessitate withdrawal of the treatment, the application must provide details of the nature and severity of this intolerance.

Failure to achieve biochemical control is defined as:

1) Growth hormone level is greater than 2.5 mcg/L; and

2) IGF-1 level is greater than 1.3 times the age- and sex-adjusted ULN

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as:

1) Growth hormone (GH) levels of less than 2.5 mcg/L; and

2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)

The authority application must be made in writing and must include:

a) a completed authority prescription form; and

b) a completed Acromegaly PBS Authority Application - Supporting Information Form; and

c) a signed patient acknowledgment; and

d) in a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided; and

e) a recent copy of GH and IGF-1 levels must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Acromegaly

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have received non-PBS treatment with this drug for this condition prior to 1 September 2016.

Population criteria:

- Patient must be aged 18 years or older.

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as:

1) Growth hormone (GH) levels of less than 2.5 mcg/L; and

2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)

The authority application must be made in writing and must include:

a) a completed authority prescription form; and

b) a completed Acromegaly PBS Authority Application - Supporting Information Form; and

c) a signed patient acknowledgment; and

d) in a patient who has previously been treated with radiotherapy for this condition, the date of completion of radiotherapy must be provided; and a copy of GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Acromegaly

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- The treatment must not be given concomitantly with PBS-subsidised pegvisomant.

Population criteria:

- Patient must be aged 18 years or older.

In a patient treated with radiotherapy, pasireotide should be withdrawn every 2 years in the 10 years after completion of radiotherapy for assessment of remission. Pasireotide should be withdrawn at least 8 weeks prior to the assessment of remission.

Biochemical evidence of remission is defined as:

1) Growth hormone (GH) levels of less than 2.5 mcg/L; and

2) normalisation of sex- and age- adjusted insulin-like growth factor 1 (IGF-1)

In a patient who has been previously treated with radiotherapy for this condition, the date of completion of radiotherapy and the GH and IGF-1 levels taken at the most recent two yearly assessment in the 10 years after completion of radiotherapy must be provided at the time of approval.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authorisation under this criterion should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pasireotide 40 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10883T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*7800.00	Signifor LAR [NV]

pasireotide 60 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10882R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*7800.00	Signifor LAR [NV]

pasireotide 20 mg injection: modified release [1 vial] (&) inert substance diluent [2 mL syringe], 1 pack

10886Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*7800.00	Signifor LAR [NV]

ANTIINFECTIVES FOR SYSTEMIC USE

ANTIBACTERIALS FOR SYSTEMIC USE

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

AZITHROMYCIN

Authority required (STREAMLINED)

6356

Mycobacterium avium complex infection

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be human immunodeficiency virus (HIV) positive, **AND**
- Patient must have CD4 cell counts of less than 75 per cubic millimetre.

azithromycin 600 mg tablet, 8

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5616N	2	5	..	*110.76	Zithromax [PF]

CLARITHROMYCIN

Authority required (STREAMLINED)

5874

Mycobacterium avium complex infection

clarithromycin 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5624B	1	2	..	31.33	APO-Clarithromycin [TX]

ANTIMYCOBACTERIALS

DRUGS FOR TREATMENT OF TUBERCULOSIS

Antibiotics

RIFABUTIN

Authority required (STREAMLINED)

6350

Mycobacterium avium complex infection

Clinical criteria:

- Patient must be human immunodeficiency virus (HIV) positive.

Authority required (STREAMLINED)

6356

Mycobacterium avium complex infection

Clinical criteria:

- The treatment must be for prophylaxis, **AND**
- Patient must be human immunodeficiency virus (HIV) positive, **AND**
- Patient must have CD4 cell counts of less than 75 per cubic millimetre.

rifabutin 150 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9541E	4	5	..	*615.00	Mycobutin [PF]

ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

GANCICLOVIR

Authority required (STREAMLINED)

4972

Cytomegalovirus disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a bone marrow transplant recipient at risk of cytomegalovirus disease.

Authority required (STREAMLINED)

4999

Cytomegalovirus disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a solid organ transplant recipient at risk of cytomegalovirus disease.

ganciclovir 500 mg injection, 5 vials

5749N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	1	..	*532.00	Cymevene [RO]

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10638X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	210.00	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10914K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	70.00	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10646H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	5	..	140.00	Ibavyr [IX]

▪ RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

ribavirin 600 mg tablet, 28

10663F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	210.00	Ibavyr [IX]

ribavirin 200 mg tablet, 28

10929F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	70.00	Ibavyr [IX]

ribavirin 400 mg tablet, 28

10678B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	140.00	Ibavyr [IX]

▪ VALACICLOVIR

Authority required (STREAMLINED)

5975

Cytomegalovirus infection and disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must have undergone a renal transplant, **AND**
- Patient must be at risk of cytomegalovirus disease.

valaciclovir 500 mg tablet, 100

9568N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
5	2	..	*221.00	[a] APO-Valaciclovir [TX]	[a] Valaciclovir RBX [RA]
		[B]2.20	*223.20	[a] Valtrex [RW]	

▪ VALGANCICLOVIR

Authority required (STREAMLINED)

4989

Cytomegalovirus infection and disease

Treatment Phase: Prophylaxis

Clinical criteria:

- Patient must be a solid organ transplant recipient at risk of cytomegalovirus disease.

valganciclovir 50 mg/mL powder for oral liquid, 100 mL

9655E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11	5	..	*4346.10	Valcyte [RO]

valganciclovir 450 mg tablet, 60

9569P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*3584.30	[a] Valcyte [RO]	[a] Valganciclovir AN [EA]
				[a] Valganciclovir Juno [JU]	[a] Valganciclovir Mylan [AF]
				[a] Valganciclovir Sandoz [SZ]	

Other antivirals

▪ DACLATASVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

daclatasvir 30 mg tablet, 28

10629K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	7666.67	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

10641C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	7666.67	Daklinza [BQ]

▪ DACLATASVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

daclatasvir 30 mg tablet, 28

10651N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	2	..	7666.67	Daklinza [BQ]

daclatasvir 60 mg tablet, 28

10660C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	7666.67	Daklinza [BQ]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

10978T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	21000.00	Zepatier [MK]

▪ ELBASVIR + GRAZOPREVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 16 weeks.

elbasvir 50 mg + grazoprevir 100 mg tablet, 28

10986F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	3	..	21000.00	Zepatier [MK]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

10661D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	22066.67	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 8 weeks.

HSD (Public)

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10667K	1	1	..	22066.67	Harvoni [GI]

▪ LEDIPASVIR + SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

ledipasvir 90 mg + sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10669M	1	5	..	22066.67	Harvoni [GI]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR

Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56], 4 x 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10751W	1	2	..	13853.13	Viekira Pak [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.
Note Special Pricing Arrangements apply.

Authority required
Chronic hepatitis C infection
Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10768R	1	5	..	13853.13	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10752X	1	5	..	13853.13	Viekira Pak-RBV [VE]

▪ PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN

Caution Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

Population criteria:

- Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 600 mg tablet [56], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10754B	1	2	..	13853.13	Viekira Pak-RBV [VE]

paritaprevir 75 mg + ritonavir 50 mg + ombitasvir 12.5 mg tablet [56] (&) dasabuvir 250 mg tablet [56] (&) ribavirin 200 mg tablet [168], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10765N	1	2	..	13853.13	Viekira Pak-RBV [VE]

▪ SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10625F	1	2	..	19297.75	Sovaldi [GI]

▪ SOFOSBUVIR

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 24 weeks.

sofosbuvir 400 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10648K	1	5	..	19297.75	Sovaldi [GI]

▪ SOFOSBUVIR + VELPATASVIR

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

sofosbuvir 400 mg + velpatasvir 100 mg tablet, 28

11145N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	22066.67	Epclusa [GI]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ANTINEOPLASTIC AGENTS

ANTIMETABOLITES

Pyrimidine analogues

AZACITIDINE

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be classified as Intermediate-2 according to the International Prognostic Scoring System (IPSS); OR
- The condition must be classified as high risk according to the International Prognostic Scoring System (IPSS).

Classification of the condition as Intermediate-2 requires a score of 1.5 to 2.0 on the IPSS, achieved with the possible combinations:

a. 11% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 0 to 1 cytopenias; OR

b. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 0 to 1 cytopenias; OR

c. 11% to 20% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR

d. 5% to 10% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

e. 5% to 10% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias; OR

f. Less than 5% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), and 2 to 3 cytopenias.

Classification of the condition as high risk requires a score of 2.5 or more on the IPSS, achieved with the possible combinations:

a. 21% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR

b. 21% to 30% marrow blasts with intermediate (other abnormalities) or poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

c. 11% to 20% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR

d. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias.

The first authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and

(d) a copy of the full blood examination report; and

(e) a copy of the pathology report detailing the cytogenetics demonstrating intermediate-2 or high risk disease according to the International Prognostic Scoring System (IPSS); and

(f) a signed patient acknowledgment form.

No more than 3 cycles will be authorised.

Authority required

Chronic Myelomonocytic Leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must have 10% to 29% marrow blasts without Myeloproliferative Disorder.

HSD (Public)

The first authority application must be made in writing and must include:
(a) a completed authority prescription form; and
(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and
(c) a copy of the bone marrow biopsy report demonstrating that the patient has chronic myelomonocytic leukaemia ; and
(d) a copy of the full blood examination report; and
(e) a signed patient acknowledgement.
No more than 3 cycles will be authorised.

Authority required

Acute Myeloid Leukaemia

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must have 20% to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification.

The first authority application must be made in writing and must include:
(a) a completed authority prescription form; and
(b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and
(c) a copy of the bone marrow biopsy report demonstrating that the patient has acute myeloid leukaemia; and
(d) a copy of the full blood examination report; and
(e) a signed patient acknowledgement.
No more than 3 cycles will be authorised.

azacitidine 100 mg injection, 1 vial

9597D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
14	2	..	*5172.16	[a] Azacitidine Accord [OC] [a] Azadine [RZ] [a] Vidaza [CJ]	[a] AZACITIDINE DR.REDDY'S [RI] [a] Celazadine [JU]

▪ AZACITIDINE

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Myelodysplastic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must be classified as Intermediate-2 according to the International Prognostic Scoring System (IPSS); OR
- The condition must be classified as high risk according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

Authority required

Chronic Myelomonocytic Leukaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must have 10% to 29% marrow blasts without Myeloproliferative Disorder, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

Authority required

Acute Myeloid Leukaemia

Treatment Phase: Continuing treatment

Clinical criteria:

- The condition must have 20% to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification, **AND**
- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not have progressive disease.

Applications for continuing therapy may be made by telephone.
Up to 6 cycles will be authorised.

azacitidine 100 mg injection, 1 vial

9598E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
14	5	..	*5172.16	[a] Azacitidine Accord [OC] [a] Azadine [RZ] [a] Vidaza [CJ]	[a] AZACITIDINE DR.REDDY'S [RI] [a] Celazadine [JU]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

▪ DOXORUBICIN HYDROCHLORIDE-PEGYLATED LIPOSOMAL

Authority required (STREAMLINED)

6234

Kaposi sarcoma

Clinical criteria:

- The condition must be AIDS-related, **AND**
- Patient must have a CD4 cell count of less than 200 per cubic millimetre, **AND**
- The condition must include extensive mucocutaneous involvement.

Authority required (STREAMLINED)

6274

Kaposi sarcoma

Clinical criteria:

- The condition must be AIDS-related, **AND**
- Patient must have a CD4 cell count of less than 200 per cubic millimetre, **AND**
- The condition must include extensive visceral involvement.

doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial

5705G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*1059.20	[a] Caelyx [JC]	[a] Liposomal Doxorubicin SUN [RA]

OTHER ANTINEOPLASTIC AGENTS

Monoclonal antibodies

▪ RITUXIMAB

Note Risk of end-organ damage or mortality includes a minimum of one of the following:Glomerulonephritis with risk of progression

- Risk to sight including scleritis/episcleritis, sudden visual loss, uveitis, retinal changes (vasculitis/thrombosis/exudates/haemorrhage)
- Bronchial/subglottic obstruction
- Pulmonary haemorrhage
- Parenchymal lung disease
- Sensory neural hearing loss
- Recurrent sinonasal disease requiring recurrent surgical interventions
- Meningitis, organic confusion, seizures, stroke, cord lesion, cranial nerve palsy, sensory peripheral neuropathy, motor mononeuritis multiplex

Note Patients could be considered contraindicated, refractory, or unable to tolerate cyclophosphamide for one of the following reasons: Cyclophosphamide is contraindicated as per the TGA approved Product Information;

- Cyclophosphamide is not recommended due to the need to preserve gonad function;
- Patient experiences severe toxicity to cyclophosphamide that warrants cessation of treatment;
- Patient has life- or organ-threatening deterioration at any time during treatment with cyclophosphamide, where the deterioration is thought to be due to severe uncontrolled active vasculitis;
- Commencing a further treatment cycle with cyclophosphamide would exceed the maximum cumulative dose of cyclophosphamide of 25g; or
- Patient's condition with this indication is persistent despite at least 3 months therapy with cyclophosphamide.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment.

Authority required

Severe active granulomatosis with polyangiitis (Wegeners granulomatosis)

Treatment Phase: Induction of remission

Clinical criteria:

- The treatment must be for the induction of remission, **AND**
- Patient must not have previously received this drug for this condition; OR
- Patient must have received this drug for this condition prior to 1 January 2016, **AND**
- The treatment must in combination with glucocorticoids, **AND**

- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance of remission

The authority application must be made in writing

Authority required

Severe active microscopic polyangiitis

Treatment Phase: Induction of remission

Clinical criteria:

- The treatment must be for the induction of remission, **AND**
- Patient must not have previously received this drug for this condition; OR
- Patient must have received this drug for this condition prior to 1 January 2016, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance therapy.

The authority application must be made in writing

Authority required

Severe active granulomatosis with polyangiitis (Wegeners granulomatosis)

Treatment Phase: Re-induction of remission

Clinical criteria:

- The treatment must be for the re-induction of remission, **AND**
- Patient must have previously received and responded to this drug for this condition, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance of remission

The authority application must be made in writing

Authority required

Severe active microscopic polyangiitis

Treatment Phase: Re-induction of remission

Clinical criteria:

- The treatment must be for the re-induction of remission, **AND**
- Patient must have previously received and responded to this drug for this condition, **AND**
- The treatment must in combination with glucocorticoids, **AND**
- Patient must be at risk of end-organ damage or mortality, **AND**
- Patient must be contraindicated, refractory or unable to tolerate cyclophosphamide.

Diagnosis should be made according to the Chapel Hill Consensus Conference Nomenclature of the Vasculitides with anti-neutrophil cytoplasmic antibody (ANCA) positive serology.

This drug is not PBS-subsidised for maintenance therapy.

The authority application must be made in writing

rituximab 100 mg/10 mL injection, 2 x 10 mL vials

10591K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	730.79	Mabthera [RO]

rituximab 500 mg/50 mL injection, 50 mL vial

10593M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1826.94	Mabthera [RO]

▪ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Colony stimulating factors

▪ FILGRASTIM

Authority required (STREAMLINED)

6544

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required (STREAMLINED)

6522

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6545

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6532

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6515

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6492

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6507

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required (STREAMLINED)

6533

Chemotherapy-induced neutropenia

Clinical criteria:

HSD (Public)

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required (STREAMLINED)

6523

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required (STREAMLINED)

6534

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required (STREAMLINED)

6535

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required (STREAMLINED)

6536

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required (STREAMLINED)

6493

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

Authority required (STREAMLINED)

6502

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required (STREAMLINED)

6516

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

Authority required (STREAMLINED)

6653

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be to facilitate harvest of peripheral blood progenitor cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy.

Authority required (STREAMLINED)

6654

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be in a normal volunteer for use in allogeneic transplantation.

Authority required (STREAMLINED)

6679

Assisting bone marrow transplantation

Clinical criteria:

- Patient must be receiving marrow-ablative chemotherapy prior to the transplantation.

Authority required (STREAMLINED)

6655

Assisting autologous peripheral blood progenitor cell transplantation

Clinical criteria:

- The treatment must be following marrow-ablative chemotherapy for non-myeloid malignancy prior to the transplantation.

Authority required (STREAMLINED)

6680

HSD (Public)

Severe congenital neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 100 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, **AND**
- Patient must have had a bone marrow examination that has shown evidence of maturational arrest of the neutrophil lineage.

Authority required (STREAMLINED)

6621

Severe chronic neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 1,000 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart; OR
- Patient must have neutrophil dysfunction, **AND**
- Patient must have experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics in the previous 12 months; OR
- Patient must have had at least 3 recurrent clinically significant infections in the previous 12 months.

Authority required (STREAMLINED)

6640

Chronic cyclical neutropenia

Clinical criteria:

- Patient must have an absolute neutrophil count of less than 500 million cells per litre lasting for 3 days per cycle, measured over 3 separate cycles, **AND**
- Patient must have experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics; OR
- Patient must have had at least 3 recurrent clinically significant infections in the previous 12 months.

filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2758E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	11	..	*914.36	Zarzio [SZ]

filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes

5829T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*365.74	Nivestim [PF]

filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes

1126G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1465.78	TevaGrastim [TB]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

5744H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1465.78	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9694F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1465.78	Nivestim [PF]

filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials

5743G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*1465.78	Neupogen [AN]

filgrastim 300 microgram/mL injection, 10 x 1 mL vials

5741E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*914.36	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2783L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	4	11	..	*1465.76	Zarzio [SZ]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

1123D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*914.36	TevaGrastim [TB]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

5742F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*914.36	Neupogen [AN]

HSD (Public)

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9692D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*914.36	Nivestim [PF]

▪ LENOGRASTIM

Authority required (STREAMLINED)

6522

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6532

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6507

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required (STREAMLINED)

6523

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required (STREAMLINED)

6535

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required (STREAMLINED)

6502

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required (STREAMLINED)

6516

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

Authority required (STREAMLINED)

6644

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Ewing's sarcoma.

Authority required (STREAMLINED)

6673

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin's lymphoma (intermediate or high grade).

Authority required (STREAMLINED)

6634

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in osteosarcoma.

Authority required (STREAMLINED)

6682

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in rhabdomyosarcoma.

Authority required (STREAMLINED)

6653

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be to facilitate harvest of peripheral blood progenitor cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy.

Authority required (STREAMLINED)

6654

Mobilisation of peripheral blood progenitor cells

Clinical criteria:

- The treatment must be in a normal volunteer for use in allogeneic transplantation.

Authority required (STREAMLINED)

6657

Assisting peripheral blood progenitor cell or bone marrow transplantation

Clinical criteria:

- The treatment must be following marrow-ablative chemotherapy for non-myeloid malignancy prior to the transplantation.

LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10

5787N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*973.76	Granocyte 13 [PF]

LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10

5788P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	11	..	*2438.84	Granocyte 34 [PF]

▪ LIPEGFILGRASTIM

Authority required (STREAMLINED)

6522

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6544

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required (STREAMLINED)

6545

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**

- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6532

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6515

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6492

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6507

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required (STREAMLINED)

6533

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required (STREAMLINED)

6523

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required (STREAMLINED)

6534

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required (STREAMLINED)

6535

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required (STREAMLINED)

6536

Chemotherapy-induced neutropenia

HSD (Public)

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required (STREAMLINED)

6493

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

lipegfilgrastim 6 mg/0.6 mL injection, 0.6 mL syringe

10936N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	11	..	1250.00	Lonquex [TB]

▪ PEGFILGRASTIM

Authority required (STREAMLINED)

6544

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be undergoing induction or consolidation therapy for acute myeloid leukaemia.

Authority required (STREAMLINED)

6522

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving standard dose adjuvant chemotherapy for breast cancer, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6545

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must must be receiving chemotherapy with fludarabine and cyclophosphamide for B-cell chronic lymphocytic leukaemia, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6532

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving first-line chemotherapy for Hodgkin disease, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6515

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving chemotherapy for myeloma, **AND**
- Patient must have had a prior episode of febrile neutropenia, **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6492

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil for inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx, **AND**
- Patient must have had a prior episode of febrile neutropenia; OR
- Patient must have had a prior episode of prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), **AND**
- The treatment must be used in a patient for whom there is a clinical justification for wishing to continue chemotherapy with the same drug combination, dosage and treatment schedule, **AND**
- Patient must be anticipated to have a good response to treatment providing chemotherapy can be delivered as planned.

Authority required (STREAMLINED)

6507

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia.

Authority required (STREAMLINED)

6533

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide) with the intention of achieving a cure or substantial remission in breast cancer.

Authority required (STREAMLINED)

6523

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours.

Authority required (STREAMLINED)

6534

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen).

Authority required (STREAMLINED)

6535

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease.

Authority required (STREAMLINED)

6536

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma.

Authority required (STREAMLINED)

6493

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy (first-line chemotherapy with escalated BEACOPP) with the intention of achieving a cure or substantial remission in Hodgkin disease.

Authority required (STREAMLINED)

6502

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in an infant or child with central nervous system tumours.

Authority required (STREAMLINED)

6516

Chemotherapy-induced neutropenia

Clinical criteria:

- Patient must be receiving treatment with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma.

pegfilgrastim 6 mg/0.6 mL injection, 0.6 mL syringe

9514R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11	..	1250.00	[a] Neulasta [AN]	[a] Ristempa [GV]

Interferons

▪ INTERFERON ALFA-2A

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)

5042

Chronic Myeloid Leukaemia (CML)

Clinical criteria:

- The condition must be Philadelphia chromosome positive.

interferon alfa-2a 3 million units/0.5 mL injection, 0.5 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5759D	30	5	..	*849.30	Roferon-A [RO]

interferon alfa-2a 9 million units/0.5 mL injection, 0.5 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5762G	30	5	..	*2547.30	Roferon-A [RO]

▪ INTERFERON ALFA-2B

Caution Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)

5042

Chronic Myeloid Leukaemia (CML)

Clinical criteria:

- The condition must be Philadelphia chromosome positive.

Authority required (STREAMLINED)

4974

Malignant melanoma

Clinical criteria:

- The treatment must be as adjunctive therapy to current standard care, **AND**
- Patient must have undergone surgery, **AND**
- The condition must include nodal involvement.

interferon alfa-2b 30 million units/1.2 mL injection, 1.2 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5764J	2	5	..	*566.02	Intron A Redipen [MK]

interferon alfa-2b 10 million units/mL injection, 5 x 1 mL vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5768N	3	5	..	*1415.04	Intron A [MK]

interferon alfa-2b 18 million units/3 mL injection, 3 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5766L	15	5	..	*2547.00	Intron A [MK]

interferon alfa-2b 60 million units/1.2 mL injection, 1.2 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5765K	2	5	..	*1132.02	Intron A Redipen [MK]

interferon alfa-2b 25 million units/2.5 mL injection, 2.5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5767M	15	5	..	*3537.60	Intron A [MK]

interferon alfa-2b 18 million units/1.2 mL injection, 1.2 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5763H	2	5	..	*339.60	Intron A Redipen [MK]

▪ INTERFERON GAMMA-1B

Authority required (STREAMLINED)

6222

Chronic granulomatous disease

Clinical criteria:

- Patient must have frequent and severe infections despite adequate prophylaxis with antimicrobial agents.

interferon gamma-1b 2 million units (100 microgram)/0.5 mL injection, 6 x 0.5 mL vials

5769P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	11	..	*2585.72	Imukin [BY]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Note Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:
(a) a nurse educator/counsellor for patients; and
(b) 24-hour access by patients to medical advice; and
(c) an established liver clinic.

Authority required (STREAMLINED)

5004

Chronic hepatitis C infection

Treatment criteria:

- Must be treated in an accredited treatment centre.

Population criteria:

- Patient must be aged 18 years or older, **AND**
- Patient must not be pregnant or breastfeeding, and must be using an effective form of contraception if female and of child-bearing age.

Clinical criteria:

- Patient must have compensated liver disease, **AND**
- Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**
- Patient must have a contraindication to ribavirin, **AND**
- The treatment must cease unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**
- The treatment must be limited to a maximum duration of 48 weeks.

Evidence of chronic hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

9516W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2565.44	Pegasys [RO]

peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes

9515T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2215.22	Pegasys [RO]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Chronic hepatitis C infection

Clinical criteria:

- Patient must meet the criteria set out in the General Statement for Drugs for the Treatment of Hepatitis C, **AND**
- Patient must be taking this drug as part of a regimen set out in the matrix in the General Statement for Drugs for the Treatment of Hepatitis C, based on the hepatitis C virus genotype, patient treatment history and cirrhotic status, **AND**
- The treatment must be limited to a maximum duration of 12 weeks.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

11026H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	2	..	1282.72	Pegasys [RO]

Other immunostimulants

▪ PLERIXAFOR

Note Applications for increased maximum quantities will only be authorised for patients with body weight greater than 100 kg.

Authority required (STREAMLINED)

4549

Mobilisation of haematopoietic stem cells

Clinical criteria:

- The treatment must be in combination with granulocyte-colony stimulating factor (G-CSF), **AND**
- Patient must have lymphoma; OR
- Patient must have multiple myeloma, **AND**
- Patient must require autologous stem cell transplantation, **AND**
- Patient must have failed previous stem cell collection; OR
- Patient must be undergoing chemotherapy plus G-CSF mobilisation and their peripheral blood CD34+ count is less than 10,000 per millilitre or less than 10 million per litre on the day of planned collection; OR
- Patient must be undergoing chemotherapy plus G-CSF mobilisation and the first apheresis has yielded less than 1 million CD34+ cells/kg.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

plerixafor 24 mg/1.2 mL subcutaneous infusion injection, 1.2 mL vial

10083Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	1	..	6991.00	Mozobil [GZ]

▪ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

HSD (Public)

▪ ABATACEPT

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20

HSD (Public)

mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services

HSD (Public)

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

abatacept 250 mg injection, 1 vial

5605B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	266.34	Orencia [BQ]

▪ ALEMTUZUMAB

Note Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.
Note Special Pricing Arrangements apply.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6847

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- Patient must not receive more than one PBS-subsidised treatment per year, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

- Must be treated by a neurologist.

alemtuzumab 12 mg/1.2 mL injection, 1.2 mL vial

10232M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
3	..	..	*34182.00	Lemtrada [GZ]

▪ ALEMTUZUMAB

Note Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.
Note Special Pricing Arrangements apply.
Note No increase in the maximum quantity or number of units may be authorised.
Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

6884

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

alemtuzumab 12 mg/1.2 mL injection, 1.2 mL vial

10228H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	5	..	..	*56970.00	Lemtrada [GZ]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 4 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis). Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment - Balance of Supply

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Clinical criteria:

- Patient must have received PBS-subsidised initial supply of eculizumab for this condition, **AND**
- Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample, **AND**
- Patient must not receive more than 20 weeks supply under this restriction.

ADAMTS-13 activity result must have been submitted to the Department of Human Services. In the case that a sample for ADAMTS-13 activity taken prior to plasma exchange or infusion was not available at the time of application for **Initial Treatment,** ADAMTS-13 activity must have been measured 1-2 weeks following the last plasma exchange or infusion, and must have been submitted to the Department of Human Services within 27 days of commencement of eculizumab. The date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of the last, if any, plasma

HSD (Public)

exchange or infusion that was undertaken in the two weeks prior to collection of the ADAMTS-13 assay must also have been provided to Department of Human Services.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment.

eculizumab 300 mg/30 mL injection, 30 mL vial

10190H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	4	..	5937.50	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment, according to the specified dosage in the approved Product Information (PI).
Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis).
Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have active and progressing thrombotic microangiopathy (TMA) caused by aHUS, **AND**
- Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample taken prior to plasma exchange or infusion; or, if ADAMTS-13 activity was not collected prior to plasma exchange or infusion, patient must have platelet counts of greater than 30x10^9/L and a serum creatinine of greater than 150 mol/L, **AND**
- Patient must have a confirmed negative STEC (Shiga toxin-producing E.Coli) result if the patient has had diarrhoea in the preceding 14 days, **AND**
- Patient must have clinical features of active organ damage or impairment, **AND**
- Patient must not receive more than 4 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than 150x10^9/L; and evidence of two of the following:

(i) presence of schistocytes on blood film;

(ii) low or absent haptoglobin;

(iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) in recipients of a kidney transplant for end-stage kidney disease due to aHUS, a kidney biopsy confirming TMA; AND

(3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:
(i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or
(ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or
(iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or
(iv) a renal biopsy consistent with aHUS;
(b) onset of TMA-related neurological impairment;
(c) onset of TMA-related cardiac impairment;
(d) onset of TMA-related gastrointestinal impairment;
(e) onset of TMA-related pulmonary impairment.
Claims of non-renal TMA-related organ damage should be made at the point of application for initial PBS-subsidised eculizumab (where possible), and should be supported by objective clinical measures. The prescriber's cover letter should establish that the observed organ damage is directly linked to active and progressing TMA, particularly when indirect causes such as severe thrombocytopenia, hypertension and acute renal failure are present at the time of the initial organ impairment.
Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment.
The authority application must be in writing and must include:
(1) A completed authority prescription form; and
(2) A completed aHUS eculizumab Authority Application Supporting Information Form - Initial PBS-subsidised eculizumab treatment; and
(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and
(4) A detailed cover letter from the prescriber; and
(5) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and
(6) A measurement of body weight at the time of application; and
(7) The result of ADAMTS-13 activity on a blood sample taken prior to plasma exchange or infusion; the date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of any plasma exchanges or infusions that were undertaken in the two weeks prior to collection of the ADAMTS-13 assay; and
(8) In the case that a sample for ADAMTS-13 assay was not collected prior to plasma exchange or infusion, measurement of ADAMTS-13 activity must be taken 1-2 weeks following the last plasma exchange or infusion. The ADAMTS-13 result must be submitted to the Department of Human Services within 27 days of commencement of eculizumab treatment in order for the patient to be considered as eligible for further PBS-subsidised eculizumab treatment, under **Initial treatment 1-balance of supply**; and
(9) A confirmed negative STEC result if the patient has had diarrhoea in the preceding 14 days; and
(10) Evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records. All tests must have been performed within one month of application; and
(11) For all patients, a recent measurement of eGFR, platelets and two of either LDH, haptoglobin or schistocytes of no more than 1 week old at the time of application.

eculizumab 300 mg/30 mL injection, 30 mL vial

10191J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	5937.50	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 6 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note For patients who have received continuing treatment with PBS-subsidised eculizumab prior to 1 January 2016, this restriction is limited to 28 weeks of therapy.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis). Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;

HSD (Public)

e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Extended initial treatment - Assessment phase

Clinical criteria:

- Patient must have received treatment under the initial restriction with PBS subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 56 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure.

A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

A maximum of up to 56 weeks of treatment is allowed under this restriction, however an application must be submitted at 6 months, 12 months, 18 months and 24 months following commencing PBS-subsidised eculizumab.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Extended Initial treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before commencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant, if applicable, (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

HSD (Public)

eculizumab 300 mg/30 mL injection, 30 mL vial

10525Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	6	..	5937.50	Soliris [XI]

▪ ECULIZUMAB

Note At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 5 repeats, according to the specified dosage in the approved Product Information (PI). Applications for treatment with this drug where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis). Please consult the approved PI for information about vaccination against meningococcal infection.

Note Eculizumab is not PBS subsidised to treat TMA caused by conditions other than aHUS, such as TMA occurring in the setting of, but not limited to:
a) Active malignancy;
b) Active HIV infection;
c) Hematopoietic stem cell transplants;
d) Various drugs including quinine, high-dose calcineurin inhibitors, antiplatelet agents;
e) Certain chemotherapy drugs or immunosuppressant drugs associated with microangiopathic haemolytic anaemia/TMA;
f) Active autoimmune diseases;
In cases where alternative causes of TMA have not been adequately excluded, additional information may be required from the prescriber to clarify the diagnosis before approval of the application.

Note The Authority application should be accompanied by a cover letter from the prescriber, providing complete details on:
a) Presenting clinical features, including history, acute treatment and medications;
b) Results of testing for genetic mutations (if available);
c) Family history of aHUS, especially in first-degree relatives;
d) Patient's prior history of episodes of active and progressing TMA caused by aHUS;
e) Exclusion of alternative causes of TMA;
f) History of renal or other organ transplant (if any);
g) Any other matters considered relevant by the prescriber.
In cases where there are discordant results (for example, an equivocal biopsy result in the absence of objective evidence of haemolysis) the cover letter should articulate the prescriber's interpretation of the clinical data and how a diagnosis of aHUS is supported by the available evidence.

Note The Authority application should include the results of screening for genetic mutations known to confer a high risk of developing aHUS. The results of genetic screening should be provided whether or not a high-risk mutation has been identified.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have received treatment under Extended Initial restriction with PBS subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure.

A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

HSD (Public)

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before recommencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Extended Continuing treatment

Clinical criteria:

- Patient must have received treatment under the Continuing treatment with PBS-subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated on-going treatment response with PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must have a TMA-related cardiomyopathy as evidenced by left ventricular ejection fraction < 40% on current objective measurement; OR
- Patient must have severe TMA-related neurological impairment; OR
- Patient must have severe TMA-related gastrointestinal impairment; OR
- Patient must have severe TMA-related pulmonary impairment on current objective measurement; OR
- Patient must have grade 4 or 5 chronic kidney disease (eGFR of less than 30 mL/min); OR
- Patient must have a high risk of aHUS recurrence in the short term in the absence of continued treatment with eculizumab, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before commencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant, if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease; and

(11) A supporting statement with clinical evidence of severe TMA-related cardiomyopathy (including current LVEF result), neurological impairment, gastrointestinal impairment or pulmonary impairment; and

(12) Evidence that the patient has had a treatment response including haematological results of no more than 1 month old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 month old at the time of application; and

(13) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(14) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Note All applications should be accompanied by a detailed letter that outlines the objective evidence of high risk of critical organ damage if aHUS recurs. The following evidence may be submitted to establish the patient's level of risk of aHUS recurrence in the short term in the absence of continued treatment with eculizumab:

a) Evidence of a mutation known to confer a high risk of aHUS recurrence;

b) Past history of recurrent episodes of active and progressive TMA due to aHUS, prior to the episode that led to current use of eculizumab;

c) Past family history of aHUS recurrence, especially in first-degree relatives;

d) Past history of recurrent aHUS following renal transplant for end-stage renal failure due to aHUS.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have demonstrated treatment response to previous treatment with PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must have the following clinical conditions:(i) either significant haemolysis as measured by low/absent haptoglobin; or presence of schistocytes on the blood film; or lactate dehydrogenase (LDH) above normal;AND(ii) either platelet consumption as measured by either 25% decline from patient baseline or thrombocytopenia (platelet count <150 x 10^9/L);OR(iii) TMA-related organ impairment including on recent biopsy, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form(s); and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Recommencement of treatment; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A detailed cover letter from the prescriber; and

(5) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(6) A measurement of body weight at the time of application, and

(7) An identified genetic mutation, if applicable; and

HSD (Public)

(8) A family history of aHUS if applicable; and

(9) A history of multiple episodes of aHUS following the treatment break, if applicable; and

(10) A history of kidney transplant if applicable (especially if required due to aHUS); and

(11) An inclusion of the individual consequences of recurrent disease; and

(12) A supporting statement with clinical evidence of TMA-related organ damage including current (within one week of application) haematological results (platelet count, haptoglobin and LDH), eGFR level, and, if applicable, on recent biopsy;

(13) Evidence that the patient has had a treatment response to their previous treatment with eculizumab; and

(14) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(15) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

Note A raise in LDH alone is not a sufficient reason to re-commence eculizumab, but thrombocytopenia with one marker of haemolysis (such as raised LDH, presence of schistocytes, or low/absence of haptoglobin) is an accepted reason to consider re-commencement of eculizumab treatment.

Note Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab treatment.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing recommencement of treatment

Clinical criteria:

- Patient must have received treatment under Recommencement of treatment restriction with PBS-subsidised eculizumab for this condition, **AND**
- Patient must have demonstrated ongoing treatment response to the previous 24 weeks of PBS-subsidised eculizumab for this condition, **AND**
- Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must include the following measures of response to the prior course of treatment, including serial haematological results (every 3 months while the patient is receiving treatment).

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A detailed cover letter from the prescriber; and

(4) A copy of a current Certificate of vaccination or a statement that vaccination has or will be administered and appropriate antibiotic prophylaxis has been prescribed; and

(5) A measurement of body weight at the time of application; and

(6) An identified genetic mutation, if applicable; and

(7) A family history of aHUS, if applicable; and

(8) A history of multiple episodes of aHUS before recommencing eculizumab treatment, if applicable; and

(9) A history of kidney transplant if applicable (especially if required due to aHUS); and

(10) An inclusion of the individual consequences of recurrent disease, if applicable; and

(11) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(12) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(13) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

This assessment must be submitted no later than 4 weeks from the cessation of the prior treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with eculizumab.

eculizumab 300 mg/30 mL injection, 30 mL vial

10183Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	5937.50	Soliris [XI]

▪ EVEROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

5795

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)

5554

Management of cardiac allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

everolimus 500 microgram tablet, 60

5739C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*913.14	Certican [NV]

everolimus 750 microgram tablet, 60

5740D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
4	5	..	*2739.44	Certican [NV]

everolimus 1 mg tablet, 60

5737Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
4	5	..	*3652.56	Certican [NV]

everolimus 250 microgram tablet, 60

5738B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*456.58	Certican [NV]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

5795

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)

5554

Management of cardiac allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

mycophenolate mofetil 500 mg tablet, 50

9502D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6	5	..	*263.76	[a] APO-Mycophenolate [TX] [a] Ceptolate [AF] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Mycophenolate AN [EA] [a] Pharmacor Mycophenolate 500 [CR]

HSD (Public)

mycophenolate mofetil 1 g/5 mL powder for oral liquid, 165 mL

9500B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*489.02	CellCept [RO]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Note Management includes initiation, stabilisation and review of therapy as required.

Authority required (STREAMLINED)

4084

Prophylaxis of renal allograft rejection

Treatment Phase: Management

Clinical criteria:

- The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)

4095

WHO Class III, IV or V lupus nephritis

Treatment Phase: Management

Clinical criteria:

- The condition must be proven by biopsy.

Treatment criteria:

- Must be treated by a nephrologist or in consultation with a nephrologist.

The name of the consulting nephrologist must be included in the patient medical records.

mycophenolate 360 mg enteric tablet, 120

9504F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*343.12	Myfortic [NV]

mycophenolate 180 mg enteric tablet, 120

9503E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*171.58	Myfortic [NV]

▪ MYCOPHENOLATE

Caution Careful monitoring of patients is mandatory.

Note For item codes 9501C and 1839T, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution

Authority required (STREAMLINED)

5653

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)

5600

Management of cardiac allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of cardiac allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

mycophenolate mofetil 250 mg capsule, 100

9501C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
6	5	..	*263.88	[a] APO-Mycophenolate [TX] [a] Mycophenolate Sandoz [SZ]	[a] CellCept [RO] [a] Pharmacor Mycophenolate 250 [CR]

mycophenolate Capsule 250 mg, 50

1839T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
12	5	..	*263.88	[a] Ceptolate [AF]

▪ NATALIZUMAB

Caution Progressive multifocal leukoencephalopathy has been reported with this drug.

Authority required (STREAMLINED)

6875

Clinically definite relapsing-remitting multiple sclerosis

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must be ambulatory (without assistance or support), **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to multiple sclerosis, in the preceding 2 years, **AND**
- The condition must be confirmed by magnetic resonance imaging of the brain and/or spinal cord; OR
- Patient must be deemed unsuitable for magnetic resonance imaging due to the risk of physical (not psychological) injury to the patient.

Population criteria:

- Patient must be aged 18 years or older.

The date of the magnetic resonance imaging scan must be included in the patient's medical notes, unless written certification is provided, in the patient's medical notes, by a radiologist that an MRI scan is contraindicated because of the risk of physical (not psychological) injury to the patient.

Treatment with this drug must cease if there is continuing progression of disability whilst the patient is being treated with this drug.

For continued treatment the patient must demonstrate compliance with, and an ability to tolerate, this drug.

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

natalizumab 300 mg/15 mL injection, 15 mL vial

9505G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	1489.64	Tysabri [BD]

HSD (Public)

▪ OCRELIZUMAB

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

7411

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR
- The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**
- Patient must be ambulatory (without assistance or support).

Treatment criteria:

- Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)

7386

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not show continuing progression of disability while on treatment with this drug, **AND**
- The treatment must be a sole PBS-subsidised disease modifying therapy for this condition, **AND**
- Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

- Must be treated by a neurologist.

ocrelizumab 300 mg/10 mL injection, 10 mL vial

11242Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	..	..	*17533.00	Ocrevus [RO]

▪ SIROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

5795

Management of renal allograft rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must be receiving this drug for prophylaxis of renal allograft rejection, **AND**
- The treatment must be under the supervision and direction of a transplant unit.

sirolimus 1 mg/mL oral liquid, 60 mL

9550P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*889.20	Rapamune [PF]

sirolimus 1 mg tablet, 100

9549N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1374.32	Rapamune [PF]

sirolimus 2 mg tablet, 100

9548M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*2748.68	Rapamune [PF]

sirolimus 500 microgram tablet, 100

9747B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*687.18	Rapamune [PF]

▪ VEDOLIZUMAB

Note Special Pricing Arrangements apply.

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle. A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .

(a) Initial treatment. Applications for initial treatment should be made where:

(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).

Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.

A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving

therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab, vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.

A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.

For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

HSD (Public)

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient – Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**
- Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, and followed by a failure to achieve an adequate response to 3 or more months of treatment of an appropriately dosed thiopurine agent, **AND**
- Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR
- Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Mayo clinic or partial Mayo clinic calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment.

The most recent Mayo clinic or partial Mayo clinic score must be no more than 1 month old at the time of application.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose for patients administered doses at weeks 0, 2 and 6 (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

Patients must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Note Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Patients who have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

Note No applications for increased repeats will be authorised.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Change or Re-commencement of treatment after a break in therapy (Initial 2)

Clinical criteria:

- Patient must have previously been issued with an authority prescription for adalimumab, infliximab or vedolizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with vedolizumab for this condition more than once in the current treatment cycle, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Population criteria:

- Patient must be aged 18 years or older.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of this drug within the timelines specified in the relevant restriction. If the response assessment to the previous course of this drug is not submitted as detailed in the relevant restriction, the patient will be deemed to have failed therapy with this drug.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses of treatment may be requested by telephone by contacting the Department of Human Services.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (Change or Recommencement of treatment after a break in therapy) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (Initial 1 and Initial 2 restrictions) or 2 repeats (Continuing restriction), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial PBS-subsidised treatment (Grandfather patient)

Clinical criteria:

- Patient must have previously received non-PBS-subsidised therapy with this drug for this condition prior to 1 August 2015, **AND**
- Patient must have had a Mayo clinic score greater than or equal to 6 prior to commencing treatment with this drug; OR
- Patient must have had a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores were both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo score) prior to commencing treatment with this drug; OR
- Patient must have a documented history of moderate to severe refractory ulcerative colitis prior to having commenced treatment with this drug where a Mayo clinic, partial Mayo clinic baseline assessment is not available, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be 18 years of age or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and baseline Mayo clinic or partial Mayo clinic calculation sheet including the date of assessment of the patient's condition; and

(ii) the date of commencement of this drug; and

(iii) the signed patient acknowledgement.

The current Mayo clinic or partial Mayo clinic assessment must be no more than 1 month old at the time of application. The baseline assessment must be from immediately prior to commencing treatment with this drug. Where a baseline assessment is not available the prescriber must contact the Department of Human Services to discuss.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide for a single infusion of 300 mg per dose.

Up to a maximum of 2 repeats will be authorised.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note The patient must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

vedolizumab 300 mg injection, 1 vial

10384M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	3105.19	Entyvio [TK]

▪ VEDOLIZUMAB

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Note **TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE**

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.

HSD (Public)

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient – initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application and should be performed preferably whilst still on conventional treatment, but no longer than 1 month following cessation of the most recent prior treatment

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

Note This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of one vial of 300 mg per dose, with one dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may

HSD (Public)

be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Initial PBS-subsidised treatment (Grandfather)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously received non-PBS-subsidised therapy with this drug for this condition prior to 1 August 2015.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have had a Crohn Disease Activity Index (CDAI) Score of greater than or equal to 300 prior to commencing treatment with this drug; OR
- Patient must have a documented history of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have a documented history and radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient, **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide sufficient for a single infusion of 300 mg vedolizumab per dose. Up to a maximum of 2 repeats will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Authority required

HSD (Public)

Severe Crohn disease

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR
- Patient must have received insufficient therapy with this drug to complete 24 weeks of treatment under the Initial PBS-subsidised treatment restriction for patients who had previously received non-PBS subsidised treatment (Grandfathered patient), **AND**
- The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing or Grandfathered patients), **AND**
- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment.

Population criteria:

- Patient must be aged 18 years or older.

Note Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must be appropriately assessed for the risk of developing progressive multifocal leukoencephalopathy whilst on this treatment, **AND**
- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces: normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests and diagnostic imaging studies, must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

HSD (Public)

At the time of the authority application, medical practitioners should request the appropriate number of vials, to provide sufficient for a single infusion of 300 mg vedolizumab per dose. Up to a maximum of 2 repeats will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

vedolizumab 300 mg injection, 1 vial

10390W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	3105.19	Entyvio [TK]

Tumor necrosis factor alpha (TNF-) inhibitors

▪ ADALIMUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum

HSD (Public)

of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to

respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline

HSD (Public)

measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**
- Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

HSD (Public)

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

HSD (Public)

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9661L	1	..	..	1279.86	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9663N	1	..	..	1279.86	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9662M	1	..	..	1279.86	Humira [VE]

▪ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.

HSD (Public)

Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.
The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the

date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with etanercept, **AND**
- Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

HSD (Public)

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

5733R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	939.25	Enbrel [PF]

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

5735W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	939.25	Enbrel [PF]

etanercept 25 mg injection [4 vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

5734T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	469.63	Enbrel [PF]

▪ INFLIXIMAB

Note No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4524

Acute severe ulcerative colitis

Treatment criteria:

- Must be treated by a gastroenterologist; OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology, or general medicine specialising in gastroenterology].

Clinical criteria:

- Patient must have received an infusion of infliximab for the treatment of this condition as a hospital inpatient no more than two weeks prior to the date of the authority application, **AND**
- Patient must be an adult aged 18 years or older, and prior to initiation of infliximab treatment in hospital must have been experiencing six or more bloody stools per day, plus at least one of the following: (i) Temperature greater than 37.8 degrees Celsius; (ii) Pulse rate greater than 90 beats per minute; (iii) Haemoglobin less than 105 g/L; (iv) Erythrocyte sedimentation rate greater than 30 mm/h; OR
- Patient must be a child aged 6 to 17 years inclusive, and prior to initiation of infliximab treatment in hospital must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) greater than or equal to 65, with the diagnosis confirmed by a gastroenterologist, or a consultant physician as specified below, **AND**
- Patient must have failed to achieve an adequate response to at least 72 hours treatment with intravenous corticosteroids prior to initiation of infliximab treatment in hospital.

Population criteria:

- Patient must be 6 years of age or older.

For adults aged 18 years or older, failure to achieve an adequate response to intravenous corticosteroid treatment is defined by the Oxford criteria where:

(i) If assessed on day 3, patients pass 8 or more stools per day or 3 or more stools per day with a C-reactive protein (CRP) greater than 45 mg/L

(ii) If assessed on day 7, patients pass 3 or more stools per day with visible blood.

For children aged 6 to 17 years, failure to achieve an adequate response to intravenous corticosteroids means a PUCAI score greater than 45 at 72 hours.

At the time of authority application, prescribers should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Before administering infliximab to a child aged 6 to 17 years, the treating clinician must have consulted with a paediatric gastroenterologist or with an institution experienced in performance of paediatric colectomy. The name of the specialist or institution must be included in the patient's medical records.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

infliximab 100 mg injection, 1 vial

10067W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	1	..	*2537.10	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.
Written applications for authority to prescribe infliximab should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Note TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa

HSD (Public)

antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

HSD (Public)

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6 will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

The authority application must be made in writing

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and

(c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

HSD (Public)

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

The authority application must be made in writing

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

(a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with infliximab prior to 1 March 2010; and

(b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with infliximab; and

(c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) is receiving treatment with infliximab at the time of application; and

(e) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with infliximab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

The authority application must be made in writing

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

HSD (Public)

(b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

The authority application must be made in writing

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
9654D	1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF PAEDIATRIC PATIENTS WITH REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with adalimumab for severe refractory Crohn disease and infliximab for moderate to severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time.

For paediatric patients with Crohn disease, infliximab is PBS-subsidised for moderate to severe disease while adalimumab is PBS-subsidised for severe disease.

From 1 August 2015, under the PBS, patients commencing on adalimumab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to infliximab. Patients on infliximab will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist but will need to meet a PCDAI score of greater than or equal to 40 when swapping to adalimumab. Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2015 is considered to be in their first cycle as of 1 August 2015.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2015.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised

HSD (Public)

therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.
From 1 August 2015, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to theDepartment of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient with severe disease may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Crohn Disease Activity Index (PCDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy, immunosuppressive therapy or enteral nutrition.
Patients on infliximab may swap to adalimumab within the same treatment cycle provided that their disease severity has progressed to severe disease (i.e. they have a current PCDAI score of 40 or more).
A patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PCDAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.
Patients must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months immediately prior to the time the PCDAI score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe Crohn disease

HSD (Public)

Treatment Phase: Initial treatment (new paediatric patient) of Crohn disease in a paediatric patient assessed by PCDAI (Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist, consultant physician, paediatrician or specialist paediatric gastroenterologist, **AND**
- Patient must have failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including: (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period; (ii) an 8 week course of enteral nutrition; or (iii) immunosuppressive therapy including azathioprine at a dose of at least 2 mg per kg daily for 3 or more months, or, 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months, or, methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contra-indication to each of prednisolone (or equivalent), azathioprine, 6-mercaptopurine and methotrexate, **AND**
- Patient must have, at the time of application, disease severity considered to be moderate to severe as demonstrated by a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 30 preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment and which is no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription forms; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of previous systemic drug therapy [dosage, date of commencement and duration of therapy] or dates of enteral nutrition; and

(iii) the signed patient or guardian acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application. If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Human Services website (www.humanservices.gov.au).

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Change or re-commencement of treatment of Crohn disease in a paediatric patient assessed by PCDAI (Initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have a documented history of moderate to severe Crohn disease, **AND**
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with this drug for this condition; OR
- Patient must in this treatment cycle, have received prior PBS-subsidised treatment with adalimumab for this condition, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition more than once in the current treatment cycle.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed paediatric Crohn Disease PBS Authority Application -Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) Score calculation sheet; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of this drug may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the Balance of Supply treatment phase PBS restriction. Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

It is recommended that an application for continuing treatment is posted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Continuing treatment of Crohn disease in a paediatric patient assessed by PCDAI

Clinical criteria:

- Patient must have a documented history of moderate to severe Crohn disease.

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug as defined as a reduction in PCDAI Score by at least 15 points as compared to baseline and a total of PCDAI score of 30 points or less with the PCDAI assessment being no more than 1 month old at the time of application.

Population criteria:

- Patient must be aged 6 to 17 years inclusive.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

HSD (Public)

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Department of Human Services website (www.humanservices.gov.au)] which includes the following:

(i) the completed Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition.

The PCDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with this drug, a PCDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and authorised through the 'Balance of Supply' treatment phase PBS restriction.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe Crohn disease

Treatment Phase: Balance of supply for a paediatric patient

Treatment criteria:

- Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician or a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under Initial 1 (new patient or patient recommencing treatment after break of more than 5 years) or Initial 2 (change or recommencement of treatment after a break of less than 5 years) or Continuing treatment to complete the maximum duration of treatment specified in the relevant treatment phase, **AND**
- The treatment must provide no more than the balance of up to 3 doses or 2 repeats.

Note Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written applications for authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
5755X	1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when

swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.

HSD (Public)

(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Note No applications for increased maximum quantities will be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR
- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

HSD (Public)

- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction.

Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe Crohn disease

Treatment Phase: Balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing treatment).

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Population criteria:

- Patient must be aged 18 years or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Authority required

Severe Crohn disease

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug.

Population criteria:

- Patient must be aged 18 years or older.

Clinical criteria:

- Patient must have an adequate response to this drug defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150 if assessed by CDAI or if affected by extensive small intestine disease; OR
- Patient must have an adequate response to this drug defined as (a) an improvement of intestinal inflammation as demonstrated by: (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; or (ii) faeces:

HSD (Public)

normalisation of lactoferrin or calprotectin level; or (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or (b) reversal of high faecal output state; or (c) avoidance of the need for surgery or total parenteral nutrition (TPN), if affected by short gut syndrome, extensive small intestine or is an ostomy patient.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment.

All assessments, pathology tests, and diagnostic imaging studies must be made within 1 month of the date of application.

If the application is the first application for continuing treatment with this drug, an assessment of the patient's response to the initial course of treatment must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to the Department of Human Services within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

If fewer than the maximum stated repeats in the relevant treatment phase are requested at the time of the application, authority approvals for sufficient repeats to complete the balance of the stated repeats in the relevant treatment phase may be requested by telephone by contacting the Department of Human Services and applying through the Balance of Supply restriction. Under no circumstances will telephone approvals be granted for treatment that would otherwise extend the relevant treatment phase.

Up to a maximum of 2 repeats will be authorised.

infliximab 100 mg injection, 1 vial

5754W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of infliximab, vedolizumab and adalimumab for adult patients with ulcerative colitis. Patients are eligible for PBS-subsidised treatment with either infliximab, vedolizumab or adalimumab at any one time. From 1 December 2016, under the PBS, all adult patients will be able to commence a treatment cycle where they may trial each of PBS-subsidised infliximab, vedolizumab or adalimumab without having to experience a disease flare when swapping to one of the alternate agents. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with infliximab, vedolizumab or adalimumab while they continue to show a response to therapy. A patient who received PBS-subsidised infliximab, vedolizumab or adalimumab treatment prior to 1 December 2016 is considered to be in their first cycle as of 1 December 2016. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised infliximab, vedolizumab or adalimumab more than once. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised infliximab, vedolizumab or adalimumab treatment in the most recent cycle to the date of the first application for initial treatment with infliximab, vedolizumab or adalimumab under the new treatment cycle. A patient who has failed fewer than 3 trials of either infliximab, vedolizumab or adalimumab in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

(1) How to prescribe PBS-subsidised treatment with infliximab, vedolizumab and adalimumab after therapy after 1 December 2016 .

(a) Initial treatment. Applications for initial treatment should be made where:

(i) an adult patient has received no prior PBS-subsidised treatment with infliximab, vedolizumab or adalimumab in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) an adult patient has received prior PBS-subsidised (initial or continuing) infliximab, vedolizumab or adalimumab therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) an adult patient wishes to re-commence treatment with infliximab, vedolizumab or adalimumab following a break in PBS-subsidised therapy with the same agent (Initial 2).

Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of therapy for adalimumab , 14 weeks of therapy for infliximab and vedolizumab.

A patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab, and this assessment must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is

reviewed in the month prior to completing their current course of treatment and that an application is provided to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with infliximab, vedolizumab or adalimumab, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment. Assessments of response to a course of PBS-subsidised therapy must be provided to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not provided to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised treatment is approved, a patient may swap if eligible to the alternate infliximab, vedolizumab or adalimumab treatment within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Mayo clinic score or partial Mayo clinic score), or the prior corticosteroid therapy and immunosuppressive therapy. A patient may trial an alternate treatment at any time, regardless of whether they are receiving therapy (initial or continuing) with infliximab, vedolizumab or adalimumab at the time of the application. However, they cannot swap to a particular therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle. To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction. To avoid confusion, an application for a patient who wishes to swap to the alternate infliximab, vedolizumab or adalimumab therapy should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Mayo clinic score or partial Mayo clinic score submitted with the first authority application for infliximab, vedolizumab or adalimumab. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is provided within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised infliximab, vedolizumab or adalimumab therapy of at least 5 years, must requalify for initial treatment with respect to the scores of disease severity. A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the Mayo score is measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab.
A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 December 2016 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion. Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug. 'Grandfather' arrangements will only apply for the first treatment cycle.
For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Note TREATMENT OF PAEDIATRIC PATIENTS WITH MODERATE TO SEVERE ULCERATIVE COLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) for paediatric patients with infliximab or adalimumab for moderate to severe ulcerative colitis; and infliximab for acute severe ulcerative colitis. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to infliximab and adalimumab only.A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any one time. Infliximab and adalimumab are PBS-subsidised for moderate to severe disease while only infliximab is PBS-subsidised for acute severe disease.From 1 June 2017, under the PBS, all will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent.Under these arrangements, within a single treatment cycle and depending on the disease severity, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 June 2017 is considered to be in their first cycle as of 1 June 2017. Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice. Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle. A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle. There is no limit to the number of treatment cycles a patient may undertake in their lifetime.(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 June 2017.(a) Initial treatment.Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or (ii) a patient has received prior PBS-subsidised (initial or

HSD (Public)

HSD (Public)

continuing) treatment with a TNF-alfa antagonist and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping treatment' below]; or (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2). Treatment authorisations under Initial 1 and Initial 2 will be limited to provide for a maximum of 16 weeks of treatment for adalimumab and 14 weeks of treatment for infliximab. From 1 June 2017, a patient must be assessed for response to a course of initial PBS-subsidised treatment following a minimum of 12 weeks of treatment for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist. For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted tothe Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. For patients weighing 40 kg or greater, one prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply. Assessments of response to a course of PBS-subsidised treatment must be submitted the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.(2) Swapping treatment. Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Paediatric Ulcerative Colitis Activity Index (PUCAI) Score, confirmation of ulcerative colitis disease), or the prior conventional therapies of corticosteroids or immunosuppressives.A patient may trial an alternate agent at any time, regardless of whether they are receiving treatment (initial or continuing) with infliximab or adalimumab at the time of the application. However, a patient cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.To ensure a patient receives the maximum treatment opportunities allowed under these swapping arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the PUCAI submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time other than when an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.A patient must have received treatment with a 5-aminosalicylate oral preparation in a standard dose for induction of remission for a minimum of 3 consecutive months, and, either azathioprine or 6-mercaptopurine for a minimum of 3 consecutive months or a tapered course of oral steroids over a 6 week period followed by an appropriately dosed thiopurine agent for a minimum of 3 consecutive months (unless intolerance develops necessitating permanent treatment withdrawal to these agents) immediately prior to the time the PUCAI score is measured.(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab. A patient who commenced treatment with adalimumab for moderate to severe ulcerative colitis prior to 1 June 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 3 'grandfather' treatment restriction.A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab will be authorised under this criterion.Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab will be assessed under the continuing treatment restriction. 'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a continuing patient.

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient or Recommencement of treatment after more than 5 years break in therapy - Initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**

- Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR
- Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg (for a child, 1 to 2 mg/kg up to 40 mg) prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, and followed by a failure to achieve an adequate response to 3 or more months of treatment of an appropriately dosed thiopurine agent, **AND**
- Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR
- Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score); OR
- Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 if aged 6 to 17 years; OR
- Patient must have previously received induction therapy with this drug for an acute severe episode of ulcerative colitis in the last 4 months and demonstrated an adequate response to induction therapy by achieving and maintaining a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a PUCAI score less than 10 (if aged 6 to 17 years).

Population criteria:

- Patient must be 6 years of age or older.

Applications for authorisation of initial treatment must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement or guardian acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, or to be administered at 8-weekly intervals for patients who have received prior treatment for an acute severe episode, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior conventional treatment.

The most recent Mayo clinic, partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) score must be no more than 1 month old at the time of application.

Where treatment for an acute severe episode has occurred, an adequate response to induction therapy needs to be demonstrated by achieving and maintaining a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 (if aged 6 to 17 years), within the first 12 weeks of receiving this drug for acute severe ulcerative colitis.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 within the first 12 weeks of receiving this drug for ulcerative colitis, or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose for patients administered doses at weeks 0, 2 and 6 (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The patient or guardian (required if patient is aged 6 to 17 years) must have signed a patient acknowledgement indicating that he or she understands and acknowledges that the PBS-subsidised treatment will cease if he or she does not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR

- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR
- Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score of less than 10 while receiving treatment with this drug, if aged 6 to 17 years.

Patients who have failed to maintain a partial Mayo clinic score of less than or equal to 2, with no subscore greater than 1, or, patients who have failed to maintain a Paediatric Ulcerative Colitis Activity Index (PUCAI) score of less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

The authority application must be made in writing

Up to a maximum of 2 repeats will be authorised.

Note No applications for increased repeats will be authorised.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Change or Re-commencement of treatment after a break in therapy (Initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with adalimumab, infliximab or vedolizumab for this condition in this treatment cycle; OR
- Patient must have previously received PBS-subsidised treatment with adalimumab or infliximab for this condition in this treatment cycle if aged 6 to 17 years, **AND**
- Patient must not have failed PBS-subsidised treatment with infliximab for this condition in the current treatment cycle; OR
- Patient must not have failed PBS-subsidised treatment with infliximab for this condition in the current treatment cycle more than once if aged 6 to 17 years.

Population criteria:

- Patient must be 6 years of age or older.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of this drug within the timelines specified in the relevant restriction. If the response assessment to the previous course of this drug is not submitted as detailed in the relevant restriction, the patient will be deemed to have failed therapy with this drug.

Applications for authorisation of initial treatment must be in writing and must include:(a) a completed authority prescription form; and(b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:(i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy];

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Up to a maximum of 2 repeats will be authorised.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

Note No applications for increased repeats will be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

HSD (Public)

Reply Paid 9826
HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
- Must be treated by a paediatrician; OR
- Must be treated by a specialist paediatric gastroenterologist.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (Change or Recommencement of treatment after a break in therapy) restriction to complete the 3 doses (i.e. the initial infusion regimen at 0, 2 and 6 weeks); OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment, **AND**
- The treatment must provide no more than the balance of up to 3 doses (Initial 1 and Initial 2 restrictions) or 2 repeats (Continuing restriction).

Population criteria:

- Patient must be 6 years of age or older.

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services.

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
10196P	1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab for adult patients with active ankylosing spondylitis.

Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and secukinumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 6 bDMARDs at any 1 time.

Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy (a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 1 for recommencement after 5 years or more and initial 2 for recommencement after a break of less than 5 years).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an

alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response. The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.
However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy. A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

HSD (Public)

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

- The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**
- Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab, infliximab or secukinumab in this treatment cycle, **AND**
- Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**
- Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Note For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

---

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**
- Patient must be eligible to receive further bDMARD therapy.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

- Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 18 weeks treatment available under the above restrictions.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

- Patient must have a documented history of active ankylosing spondylitis, **AND**
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

5753T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a

HSD (Public)

patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must have not failed previous PBS-subsidised treatment with infliximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application including severity.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive

DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to a treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient infliximab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient infliximab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 22 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with infliximab, **AND**
- Patient must have received infliximab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 2 repeats will be authorised.

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient infliximab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

infliximab 100 mg injection, 1 vial

5757B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab for adult patients with severe active psoriatic arthritis.
Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.
Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab and ustekinumab only.
Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.
Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restrictions for each agent.
Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].
The duration of the break in therapy will be measured from the date the last prescription for PBS-subsidised treatment was issued in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.
Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.
Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle (Initial 2).
Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred are eligible to commence a new Cycle (Initial 1).
There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.
How to prescribe biological agents for the treatment of severe active psoriatic arthritis.
(1) Initial treatment.
Applications for initial treatment should be made where:
(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further

details are under 'Swapping therapy' below]; and
(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 1 or Initial 2).
All applications for initial treatment will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept, golimumab and secukinumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab, and 28 weeks of therapy for ustekinumab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.
Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.
(2) Continuing treatment.
Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services where applicable. Where a response assessment is not submitted where applicable, patients will be deemed to have failed to respond to treatment with that biological agent.
(3) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.
Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.
Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:
(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment within the timeframes specified in the relevant restriction.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the authority prescription or remaining repeats for the biological agent the patient is ceasing.
(4) Baseline measurements to determine response.
Determination of whether a response to treatment has been demonstrated will be based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used to determine response for all subsequent continuing treatments. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.
(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years must requalify for initial treatment with respect to both the indices of disease severity. Patients must have re-trialled treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe active psoriatic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
- Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
- Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
- Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR

HSD (Public)

- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 22 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe active psoriatic arthritis, **AND**

HSD (Public)

- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be an adult.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

infliximab 100 mg injection, 1 vial

5756Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

▪ INFLIXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, etanercept, infliximab, ixekizumab, secukinumab and ustekinumab only.

Patients receiving PBS-subsidised treatment for chronic plaque psoriasis are deemed to have commenced a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to meet the initial treatment criteria, that is they will not need to experience a disease flare, when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment.

Patients must be assessed for response to each course of treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The duration of the break in therapy is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

(i) patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or

(ii) patients who wish to recommence treatment following a break of 5 years or more and commence a new treatment cycle (Initial 1); or

(iii) patients who have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or

(iv) patients who wish to recommence treatment following a break of less than 5 years in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of treatment of adalimumab, etanercept, ixekizumab and secukinumab, 22 weeks of treatment of infliximab and 28 weeks of treatment of ustekinumab.

Grandfather patients (ixekizumab only).

Applications for patients who commenced treatment with ixekizumab for chronic plaque psoriasis prior to 1 February 2017 may be made for initial PBS-subsidised treatment as continuing therapy under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with a biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment. Approval will be based on the criteria included in the relevant restriction.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to the Department of Human Services within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course with a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with a specific biological agent it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where applicable an application is submitted to the Department of Human Services.

Where a response assessment is not submitted to the Department of Human Services where required, patients will be deemed to have failed to sustain a response to treatment with that biological agent.

HSD (Public)

(4) Swapping therapy.
Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.
To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment.
To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the prescription or remaining repeats for the agent being ceased.
(5) Baseline measurements to determine response.
Response to treatment will be determined based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.
To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatments.
(6) Recommencement of treatment after a 5-year break in PBS-subsidised therapy.
Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note No increase in the maximum number of repeats may be authorised.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Whole body (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

HSD (Public)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

HSD (Public)

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 1, Face, hand, foot (new patient (no prior biological agent) or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

- Patient must have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis, **AND**
- Patient must not have received any prior PBS-subsidised treatment with a biological agent for this condition; OR
- Patient must not have received PBS-subsidised treatment with a biological agent for at least 5 years, if they have previously received PBS-subsidised treatment with a biological agent for this condition and wish to commence a new Treatment Cycle, **AND**
- Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**
- Patient must have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot), **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

Where treatment with methotrexate, cyclosporin or acitretin is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, details must be provided at the time of application.

Where intolerance to treatment with phototherapy, methotrexate, cyclosporin or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in the patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 6 weeks treatment with phototherapy, methotrexate, cyclosporin or acitretin can be found on the Department of Human Services website (www.humanservices.gov.au)

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment – Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years)

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**
- Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents for this condition within this Treatment Cycle, **AND**
- Patient must not have failed, or ceased to respond to, PBS-subsidised therapy with this drug for the treatment of this condition in the current Treatment Cycle, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for patients who have demonstrated a response to PBS-subsidised treatment with this drug within this Treatment Cycle and who wish to recommence treatment with this drug within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised treatment with this drug has been submitted within 1 month of cessation of treatment.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

Note A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment. The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment

HSD (Public)

Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment - Initial 1, Whole body or Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2, Whole body or Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial 1, Whole body (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Whole body (change or recommencement of treatment after a break of less than 5 years) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 1, Face, hand, foot (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Initial 2, Face, hand, foot (change or recommencement of treatment after a break of less than 5 years) restriction to complete 22 weeks treatment, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the prebiological treatment baseline value for this Treatment Cycle.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

HSD (Public)

In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Face, hand, foot

Clinical criteria:

- Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**
- Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**
- Patient must have demonstrated an adequate response to their most recent course of treatment with this drug, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate), **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a dermatologist.

For the purposes of this restriction 'biological agent' means adalimumab, etanercept, infliximab, ixekizumab, secukinumab or ustekinumab.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams including the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with this drug.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.
In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department of Human Services on 1800 700 270 to discuss.

Note Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may recommence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Note It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Authority required

Severe chronic plaque psoriasis

Treatment Phase: Continuing treatment, Whole body or Continuing treatment, Face, hand, foot - balance of supply

Clinical criteria:

HSD (Public)

- Patient must have received insufficient therapy with this drug under the Continuing treatment, Whole body restriction to complete 24 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment, Face, hand, foot restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restrictions, **AND**
- The treatment must be as systemic monotherapy (other than methotrexate).

Treatment criteria:

- Must be treated by a dermatologist.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

infliximab 100 mg injection, 1 vial

5758C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	507.42	[a] Inflectra [PF] [a] Renflexis [MK]	[a] Remicade [JC]

Interleukin inhibitors

▪ ANAKINRA

Note This drug is not PBS-subsidised for conditions other than CAPS.

Authority required (STREAMLINED)

5450

Moderate to severe cryopyrin associated periodic syndromes (CAPS)

Treatment criteria:

- Must be treated by a rheumatologist or in consultation with a rheumatologist; OR
- Must be treated by a clinical immunologist or in consultation with a clinical immunologist.

A diagnosis of CAPS must be documented in the patient's medical records.

anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes

10264F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	1650.00	Kineret [FK]

▪ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have severe active juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR
- Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the

date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

HSD (Public)

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

HSD (Public)

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply.

Treatment criteria:

- Must be treated by a paediatric rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.
An adequate response to treatment is defined as:

HSD (Public)

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient

will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

10056G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	254.66	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

10077J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	102.74	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

10064Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	506.74	Actemra [RO]

▪ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR
- Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

HSD (Public)

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24

HSD (Public)

weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

HSD (Public)

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

HSD (Public)

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**
- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.
A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.
From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:
(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.
Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.
A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks

of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
(b) Continuing treatment.
Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.
A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.
(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

10058J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	254.66	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

10081N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	102.74	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

10072D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	506.74	Actemra [RO]

HSD (Public)

▪ TOCILIZUMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing)

HSD (Public)

with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

HSD (Public)

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with tocilizumab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to a treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**

HSD (Public)

- Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**
- Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

---

tocilizumab 200 mg/10 mL injection, 10 mL vial

9658H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	254.66	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

9657G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	102.74	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

9659J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	506.74	Actemra [RO]

▪ TOCILIZUMAB

Note TREATMENT OF PATIENTS WITH SEVERE ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tocilizumab for a patient who has severe active systemic juvenile idiopathic arthritis (sJIA).

From 1 May 2012, a patient receiving PBS-subsidised tocilizumab therapy is considered to be in a treatment cycle. Under these arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with PBS-subsidised tocilizumab while they continue to show a response to therapy, and

(ii) fail to respond, or to sustain a response, to PBS-subsidised tocilizumab twice.

Once a patient has either failed or ceased to respond to 2 courses of treatment, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised tocilizumab therapy before they are eligible to receive further PBS-subsidised tocilizumab therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised tocilizumab treatment was stopped to the date of the first application for initial treatment with tocilizumab under the new treatment cycle.

A patient who was receiving PBS-subsidised tocilizumab treatment immediately prior to 1 May 2012 is considered to be in their first cycle as of 1 May 2012. A patient who has had a break in tocilizumab treatment of at least 12 months immediately prior to making a new application, on or after 1 May 2012, will commence a new treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of less than 12 months may commence a second course of treatment within the same treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

(1) How to prescribe PBS-subsidised tocilizumab therapy after 1 May 2012.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised tocilizumab treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to recommence treatment with tocilizumab following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received the first course of PBS-subsidised (initial or continuing) tocilizumab therapy in a treatment cycle and is deemed to have failed to respond or sustain a response and the treating physician wishes to trial a second course, provided any break in therapy is less than 12 months (Initial 2); or

(iv) a patient wishes to recommence treatment with tocilizumab following a break in PBS-subsidised therapy of less than 12 months (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab for that course.

For second and subsequent courses of PBS-subsidised tocilizumab, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with tocilizumab, a patient may qualify to receive up to 24 weeks of continuing treatment with tocilizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted tocilizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

(2) Treatment cycle.

Once initial treatment with PBS-subsidised tocilizumab is approved, a patient deemed to have failed to respond to the first course of treatment may have a second course without having to requalify with respect to the indices of disease severity (joint count, fever and/or CRP level and platelet count) or the prior therapy requirements, except if the patient has had a break in therapy of more than 12 months.

To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant

HSD (Public)

restriction.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the relevant baseline measurements of the joint count, fever and/or CRP level and platelet count submitted with the first authority application for tocilizumab.
Where a patient is deemed to have failed to respond or to sustain a response to the first course of therapy in a treatment cycle, prescribers may provide new baseline measurements for the second course of treatment within that cycle. The Department of Human Services will assess response according to these revised baseline measurements. If new baseline measurements are not submitted with the initial application for the second course of treatment, then those submitted with the first course will be used by the Department of Human Services to assess response to the second course.
(4) Recommencement of treatment after a 12 month break in PBS-subsidised therapy.
A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised tocilizumab therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.
Withdrawal of treatment with tocilizumab should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

- Patient must have been diagnosed with systemic juvenile idiopathic arthritis, **AND**
- Patient must have received no prior PBS-subsidised treatment with tocilizumab for this condition; OR
- Patient must not have received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months, **AND**
- Patient must have polyarticular course disease which has failed to respond adequately to oral or parenteral methotrexate at a dose of at least 15 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; OR
- Patient must have polyarticular course disease and have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR
- Patient must have refractory systemic symptoms, demonstrated by an inability to decrease and maintain the dose of prednisolone (or equivalent) below 0.5 mg per kg per day following a minimum of 2 months of therapy, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

- Patient must be under 18 years of age.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

The following criteria indicate failure to achieve an adequate response to prior methotrexate therapy in a patient with polyarticular course disease and must be demonstrated in the patient at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The following criteria indicate failure to achieve an adequate response to prior therapy in a patient with refractory systemic symptoms and must be demonstrated in the patient at the time of the initial application:

(a) an active joint count of at least 2 active joints; and

(b) persistent fever greater than 38 degrees Celsius for at least 5 out of 14 consecutive days; and/or

(c) a C-reactive protein (CRP) level and platelet count above the upper limits of normal (ULN).

The baseline measurements of joint count, fever and/or CRP level and platelet count must be performed preferably whilst on treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with other treatments is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes the following:

(i) the date of assessment of severe active systemic juvenile idiopathic arthritis;

HSD (Public)

(ii) details of prior treatment including dose and duration of treatment;

(iii) pathology reports detailing CRP and platelet count where appropriate; and

(3) an acknowledgement signed by a parent or authorised guardian.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to 2 courses of treatment in a treatment cycle they will not be eligible to receive further PBS-subsidised tocilizumab therapy in that treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Note To ensure consistency in determining response, the same indices of disease severity used to establish baseline must be provided for all subsequent continuing treatment applications.

Note Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (retrial or recommencement of treatment after a break of less than 12 months)

Clinical criteria:

- Patient must have a documented history of systemic juvenile idiopathic arthritis, **AND**
- Patient must have received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months, **AND**
- Patient must not have failed to demonstrate an adequate response to PBS-subsidised therapy with tocilizumab for this condition more than once in the current treatment cycle, **AND**
- Patient must not receive more than 16 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes pathology reports detailing C-reactive protein (CRP) level and platelet count where appropriate.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to that course of treatment with tocilizumab.

An adequate response to treatment is defined as:

(a) in a patient with polyarticular course disease:

(i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

- elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

- shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) absence of fever greater than 38 degrees Celsius in the preceding seven days; and/or

(ii) a reduction in the C-reactive protein (CRP) level and platelet count by at least 30% from baseline; and/or

(iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Note Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (retrial or recommencement of treatment after a break of less than 12 months) - balance of supply

Clinical criteria:

- Patient must have received insufficient therapy under the Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) restriction to complete 16 weeks treatment; OR
- Patient must have received insufficient therapy under the Initial 2 (retrial or recommencement of treatment after a break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of systemic juvenile idiopathic arthritis, **AND**
- Patient must have demonstrated an adequate response to their most recent course of PBS-subsidised treatment with tocilizumab, **AND**
- Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

An adequate response to treatment is defined as:

(a) in a patient with polyarticular course disease:

(i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

- elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

- shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) absence of fever greater than 38 degrees Celsius in the preceding seven days; and/or

(ii) a reduction in the C-reactive protein (CRP) level and platelet count by at least 30% from baseline; and/or

(iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurements of disease severity submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form which includes baseline and current pathology reports detailing CRP and platelet count where appropriate.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

At the time of authority application, the medical practitioner must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the most recent prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may retrial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Note An assessment of the patient's response to a continuing course of therapy should be made within the 4 weeks prior to completion of that course and posted to the Department of Human Services no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Systemic juvenile idiopathic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

- Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 10 mL vial

1481Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	254.66	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 4 mL vial

1476Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	102.74	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 20 mL vial

1482B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	506.74	Actemra [RO]

▪ USTEKINUMAB

Note It is recommended that an application for continuing treatment is submitted to the Department of Human Services at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised treatment with this drug.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT PATIENTS WITH SEVERE CROHN DISEASE
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying drugs (bDMDs) for adult patients with severe Crohn disease. Where the term bDMDs appears in the following NOTES and restrictions, it refers to the tumour necrosis factor (TNF) alfa-antagonists (adalimumab and infliximab), the alpha-4 beta-7 integrin inhibitor (vedolizumab) and the human IgG1kappa monoclonal antibody (ustekinumab).
Patients are eligible for PBS-subsidised treatment with only 1 of the above PBS-subsidised biological disease modifying drugs at any one time.
From 1 September 2017, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab without having to experience a disease flare when swapping to the alternate agent. Under these arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with adalimumab, infliximab, vedolizumab or ustekinumab while they continue to show a response to therapy.
A patient who received PBS-subsidised adalimumab, infliximab,or vedolizumab treatment prior to 1 September 2017 is considered to be in their first cycle as of 1 September 2017.
Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab more than once.
Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment in the most recent cycle to the date of the first application for initial treatment with adalimumab, infliximab, vedolizumab or ustekinumab under the new treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.
A patient who has failed fewer than 3 trials of bDMD therapy in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab therapy after 1 September 2017.
(a) Initial treatment.
Applications for initial treatment should be made where:
(i) a patient has received no prior PBS-subsidised therapy with adalimumab, infliximab, vedolizumab or ustekinumab in this treatment cycle and wishes to commence such therapy (Initial 1 - new patients); or
(ii) a patient has received prior PBS-subsidised (initial or continuing) adalimumab, infliximab, vedolizumab or ustekinumab and wishes to trial an alternate agent (Initial 2 - Change or recommencement) [further details are under 'Swapping therapy' below]; or
(iii) a patient wishes to re-commence treatment with adalimumab, infliximab, vedolizumab or ustekinumab following a break in PBS-subsidised therapy with that agent (Initial 2 - Change or Re-commencement).
Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, 14 weeks of therapy for infliximab, 14 weeks of therapy for vedolizumab and 16 weeks for ustekinumab.
From 1 September 2017, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab or ustekinumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab or vedolizumab, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMD therapy.
For second and subsequent courses of PBS-subsidised adalimumab, infliximab, vedolizumab or ustekinumab treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Adalimumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats and the second prescription should be written for 2 doses of 40 mg and 2 repeats for patients weighing 40 kg or greater. For patients weighing less than 40 kg, one prescription should be written for 2 doses of 40 mg with no repeats and the second prescription should be written for 2 doses of 20 mg with 3 repeats.
Ustekinumab only: Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.
(b) Continuing treatment.
Following the completion of an initial treatment course with adalimumab, infliximab, vedolizumab or ustekinumab, a patient

HSD (Public)

may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.
It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted supply of treatment.
Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that drug.
(2) Swapping therapy.
Once initial treatment with the first PBS-subsidised bDMD therapy is approved, a patient may swap if eligible to the alternate adalimumab, infliximab, vedolizumab or ustekinumab within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, confirmation of Crohn disease), or the prior conventional therapies of corticosteroid therapy and immunosuppressive therapy.
A patient may trial the alternate bDMD therapy at any time, regardless of whether they are receiving therapy (initial or continuing) with adalimumab, infliximab, vedolizumab or ustekinumab at the time of the application. However, they cannot swap to a particular bDMD therapy if they have failed to respond to prior treatment with that drug once within the same treatment cycle.
To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.
To avoid confusion, an application for a patient who wishes to swap to adalimumab, infliximab, vedolizumab or ustekinumab (where eligible in terms of disease severity) should be accompanied by the approved authority prescription or remaining repeats for the therapy the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for adalimumab, infliximab, vedolizumab or ustekinumab. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.
A patient who wishes to trial a second or subsequent course of treatment following a break in PBS-subsidised bDMD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.
(5) Patients 'grandfathered' onto PBS-subsidised treatment with vedolizumab.
A patient who commenced treatment with vedolizumab for severe Crohn disease prior to 1 August 2015 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.
(6) Patients 'grandfathered' onto PBS-subsidised treatment with ustekinumab.
A patient who commenced treatment with ustekinumab for severe Crohn disease prior to 1 September 2017 and who continues to receive treatment at the time of application may qualify for treatment under the initial 'grandfather' treatment restriction.
A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment will be authorised under this criterion.
Following completion of the initial PBS-subsidised course, further applications for treatment will be assessed under the continuing treatment restriction of the relevant drug.
'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for continuing treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

Authority required

Severe Crohn disease

Treatment Phase: Initial treatment (new patient - initial 1)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have confirmed severe Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician, **AND**
- Patient must have failed to achieve an adequate response to prior systemic therapy with a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; OR

HSD (Public)

- Patient must have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to steroids, **AND**
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug; OR
- Patient must have failed to achieve adequate response to prior systemic immunosuppressive therapy with methotrexate at a dose of at least 15 mg weekly for 3 or more months or have a documented intolerance of a severity necessitating permanent treatment withdrawal or a contraindication to this drug, **AND**
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220 if affected by extensive small intestine disease; OR
- Patient must have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 if not affected by extensive small intestine disease, short gut syndrome or is an ostomy patient, **AND**
- Patient must have evidence of intestinal inflammation and have diagnostic imaging or surgical evidence of short gut syndrome if affected by the syndrome or has an ileostomy or colostomy; OR
- Patient must have radiological evidence of intestinal inflammation if the patient has extensive small intestinal disease affecting more than 50 cm of the small intestine; OR
- Patient must (a) have evidence of intestinal inflammation, including: (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; or (ii) faeces: higher than normal lactoferrin or calprotectin level; or (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery; or (b) be assessed clinically as being in a high faecal output state; or (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of this drug, if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition if relevant; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iv) the date of the most recent clinical assessment; and

(v) the signed patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for the subsequent first dose, containing a quantity of 2 vials of 45 mg and no repeats.

Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

If treatment with any of the specified prior conventional drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

Details of the accepted toxicities including severity can be found on the Department of Human Services website.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

Authority required

Severe Crohn disease

Treatment Phase: Change or Re-commencement of treatment (initial 2)

Treatment criteria:

- Must be treated by a gastroenterologist (code 87); OR
- Must be treated by a consultant physician [internal medicine specialising in gastroenterology (code 81)]; OR
- Must be treated by a consultant physician [general medicine specialising in gastroenterology (code 82)].

Clinical criteria:

- Patient must have a documented history of severe Crohn disease, **AND**
- Patient must have received prior PBS-subsidised treatment with a biological disease modifying drug for this condition in this treatment cycle, **AND**
- Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle.

Population criteria:

- Patient must be aged 18 years or older.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form, which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition, if relevant; or

(ii) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy for patients with short gut syndrome, extensive small intestine disease or an ostomy, if relevant; and

(iii) the date of clinical assessment; and

(iv) the details of prior biological disease modifying drug treatment including the details of date and duration of treatment.

Two completed authority prescriptions should be submitted with every initial application for this drug. One prescription should be written under S100 (Highly Specialised Drugs) for a weight-based loading dose, containing a quantity of up to 4 vials of 130 mg and no repeats. The second prescription should be written under S85 (General) for 2 vials of 45 mg and no repeats.

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of biological disease modifying drug (bDMD) therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised bDMD treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and vedolizumab and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of bDMD treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of bDMD.

A maximum quantity of a weight based loading dose is up to 4 vials with no repeats and the subsequent first dose of 90 mg (2 vials of 45 mg) with no repeats provide for an initial 16 week course of this drug will be authorised.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Note Increase in the maximum quantity or number of units up to 4 may be authorised for the purpose of weight-based loading dose.

ustekinumab 130 mg/26 mL injection, 26 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11182M	4	..	..	*16929.24	Stelara [JC]

Calcineurin inhibitors

▪ CICLOSPORIN

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

6628

Management of transplant rejection

Clinical criteria:

- The treatment must be used by organ or tissue transplant recipients.

ciclosporin 50 mg/mL injection, 10 x 1 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5631J	1	..	..	54.10	Sandimmun [NV]

▪ CICLOSPORIN

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

6643

Management of transplant rejection

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must have had an organ or tissue transplantation, **AND**

HSD (Public)

- The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)

6660

Severe atopic dermatitis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Treatment criteria:

- Must be treated by a dermatologist; OR
- Must be treated by a clinical immunologists.

Clinical criteria:

- The condition must be ineffective to other systemic therapies; OR
- The condition must be inappropriate for other systemic therapies.

Authority required (STREAMLINED)

6676

Severe psoriasis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- The condition must be ineffective to other systemic therapies; OR
- The condition must be inappropriate for other systemic therapies, **AND**
- The condition must have caused significant interference with quality of life.

Treatment criteria:

- Must be treated by a dermatologist.

Authority required (STREAMLINED)

6631

Nephrotic syndrome

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- Patient must have failed prior treatment with steroids and cytostatic drugs; OR
- Patient must be intolerant to treatment with steroids and cytostatic drugs; OR
- The condition must be considered inappropriate for treatment with steroids and cytostatic drugs, **AND**
- Patient must not have renal impairment.

Treatment criteria:

- Must be treated by a nephrologist.

Authority required (STREAMLINED)

6638

Severe active rheumatoid arthritis

Treatment Phase: Management (initiation, stabilisation and review of therapy)

Clinical criteria:

- The condition must have been ineffective to prior treatment with classical slow-acting anti-rheumatic agents (including methotrexate); OR
- The condition must be considered inappropriate for treatment with slow-acting anti-rheumatic agents (including methotrexate).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist.

ciclosporin 10 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5632K	2	5	..	*74.40	Neoral 10 [NV]

ciclosporin 50 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
5635N	4	5	..	*268.16	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 50 [NV]

ciclosporin 100 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
5636P	4	5	..	*546.40	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 100 [NV]

ciclosporin 25 mg capsule, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
5634M	4	5	..	*128.88	[a] Cyclosporin Sandoz [SZ]	[a] Neoral 25 [NV]

ciclosporin 100 mg/mL oral liquid, 50 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5633L	4	5	..	*1263.16	Neoral [NV]

▪ TACROLIMUS

Caution Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

5569

Management of rejection in patients following organ or tissue transplantation

Clinical criteria:

- The treatment must be under the supervision and direction of a transplant unit, **AND**
- The treatment must include initiation, stabilisation, and review of therapy as required.

tacrolimus 1 mg modified release capsule, 60

9665Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*263.28	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 5 mg capsule, 50

9561F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*1096.44	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 500 microgram modified release capsule, 30

9664P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*75.04	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 750 microgram capsule, 100

10859M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*375.00	Tacrolimus Sandoz [SZ]

tacrolimus 5 mg modified release capsule, 30

9666R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*750.44	[a] ADVAGRAF XL [LQ]	[a] Prograf XL [LL]

tacrolimus 500 microgram capsule, 100

9558C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*219.40	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 0.5 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 1 mg capsule, 100

9560E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*438.80	[a] Pacrolim [AF] [a] Prograf [LL] [a] Tacrolimus Sandoz [SZ]	[a] Pharmacor Tacrolimus 1 [CR] [a] TACROLIMUS APOTEX [TX]

tacrolimus 2 mg capsule, 100

10860N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	5	..	*1000.00	Tacrolimus Sandoz [SZ]

Other immunosuppressants

▪ LENALIDOMIDE

Note Special Pricing Arrangements apply.

Authority required

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be limited to a maximum duration of 16 weeks, **AND**
- Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**
- Patient must be red blood cell transfusion dependent.

Classification of a patient as Low risk requires a score of 0 on the IPSS, achieved with the following combination: less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias.

Classification of a patient as Intermediate-1 requires a score of 0.5 to 1 on the IPSS, achieved with the following possible combinations:

1. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias; OR
2. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
3. less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
4. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 2/3 cytopenias; OR
5. 5%-10% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR

HSD (Public)

6. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
7. less than 5% marrow blasts with poor karyotypic status (complex, greater than 3 abnormalities), and 0/1 cytopenias.

Classification of a patient as red blood cell transfusion dependent requires that:

(i) the patient has been transfused within the last 8 weeks; and

(ii) the patient has received at least 8 units of red blood cell in the last 6 months prior to commencing PBS-subsidised therapy with lenalidomide; and would be expected to continue this requirement without lenalidomide treatment.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Myelodysplastic Syndrome Lenalidomide Authority Application - Supporting Information Form; and

(c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and

(d) a copy of the full blood examination report; and

(e) a copy of the pathology report detailing the cytogenetics demonstrating Low risk or Intermediate-1 disease according to the IPSS (note: using Fluorescence in Situ Hybridization (FISH) to demonstrate MDS -5q is acceptable); and

(f) details of transfusion requirements including: (i) the date of most recent transfusion and the number of red blood cell units transfused; and (ii) the total number of red cell units transfused in the 4 and 6 months preceding the date of this application; and

(g) a signed patient acknowledgement form.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**
- Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**
- Patient must have received PBS-subsidised initial therapy with lenalidomide for myelodysplastic syndrome, **AND**
- Patient must have achieved and maintained transfusion independence; or least a 50% reduction in red blood cell unit transfusion requirements compared with the four month period prior to commencing initial PBS-subsidised therapy with lenalidomide, **AND**
- Patient must not have progressive disease.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The first authority application for continuing supply must be made in writing. Subsequent authority applications for continuing supply may be made by telephone.

The following evidence of response must be provided at each application:

(i) a haemoglobin level taken within the last 4 weeks; and

(ii) the date of the last transfusion; and

(iii) a statement of the number of units of red cells transfused in the 4 months immediately preceding this application; and

(iv) a statement confirming that the patient has not progressed to acute myeloid leukaemia.

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Subsequent authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

lenalidomide 5 mg capsule, 21

2799H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	3	..	5122.76	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

2802L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	3	..	5361.16	Revlimid [CJ]

▪ LENALIDOMIDE

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial PBS-subsidised treatment

Clinical criteria:

- The condition must be confirmed by a histological diagnosis, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with dexamethasone, **AND**
- Patient must have progressive disease after at least one prior therapy, **AND**
- Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, prior treatments including name(s) of drug(s) and date of most recent treatment cycle and record of prior stem cell transplant or ineligibility for prior stem cell transplant; details of the basis of the diagnosis of progressive disease or failure to respond; and nomination of which disease activity parameters will be used to assess response; and

(3) a signed patient acknowledgment.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

(a) the level of serum monoclonal protein; or

(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or

(c) the serum level of free kappa and lambda light chains; or

(d) bone marrow aspirate or trephine; or

(e) if present, the size and location of lytic bone lesions (not including compression fractures); or

(f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or

(g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Multiple myeloma

Treatment Phase: Continuing PBS-subsidised treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised treatment with this drug for relapsed or refractory multiple myeloma, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be in combination with dexamethasone, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services

HSD (Public)

Complex Drugs
Reply Paid 9826
HOBART TAS 7001

lenalidomide 15 mg capsule, 21

5785L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6252.53	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

5783J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5122.76	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

5786M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6587.49	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

5784K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5361.16	Revlimid [CJ]

▪ LENALIDOMIDE

Caution This drug is a category X drug and must not be given to pregnant women. If lenalidomide is taken during pregnancy, a teratogenic effect of lenalidomide in humans cannot be ruled out.

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial treatment

Clinical criteria:

- The condition must be newly diagnosed, **AND**
- The condition must be confirmed by a histological diagnosis, **AND**
- Patient must be ineligible for a primary stem cell transplantation, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues, **AND**
- The treatment must be in combination with dexamethasone.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, and ineligibility for prior stem cell transplant; and nomination of which disease activity parameters will be used to assess response; and

(3) a signed patient acknowledgement.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

(a) the level of serum monoclonal protein; or

(b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or

(c) the serum level of free kappa and lambda light chains; or

(d) bone marrow aspirate or trephine; or

(e) if present, the size and location of lytic bone lesions (not including compression fractures); or

(f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or

(g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note Patient must be registered in the i-access risk management program.

Authority required

Multiple myeloma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been authorised with a PBS prescription with this drug for the condition, **AND**
- Patient must not have demonstrated progressive disease, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues, **AND**
- The treatment must be in combination with dexamethasone.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

lenalidomide 15 mg capsule, 21

11062F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6252.53	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

11029L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5122.76	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

11041D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	6587.49	Revlimid [CJ]

lenalidomide 10 mg capsule, 21

11064H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	5361.16	Revlimid [CJ]

▪ POMALIDOMIDE

Caution This drug is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Note Special Pricing Arrangements apply.

Authority required

Multiple myeloma

Treatment Phase: Initial treatment

Clinical criteria:

- The treatment must be in combination with dexamethasone, **AND**
- Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**
- Patient must have experienced treatment failure with lenalidomide, **AND**
- Patient must have experienced treatment failure with bortezomib, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Bortezomib treatment failure is the absence of achieving at least a partial response or as progressive disease during treatment or within 6 months of discontinuing treatment with bortezomib. Lenalidomide treatment failure is progressive disease during treatment or within 6 months of discontinuing treatment with lenalidomide.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Multiple Myeloma pomalidomide Authority Application Supporting Information form; and

(3) reports demonstrating the patient has failed treatment with lenalidomide and bortezomib.

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

HSD (Public)

Authority required

Multiple myeloma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must not have progressive disease, **AND**
- The treatment must be in combination with dexamethasone, **AND**
- Patient must not be receiving concomitant PBS-subsidised bortezomib, thalidomide or its analogues.

Progressive disease is defined as at least 1 of the following:

(a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or

(b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or

(c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or

(d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or

(e) an increase in the size or number of lytic bone lesions (not including compression fractures); or

(f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or

(g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Patients receiving this drug under the PBS listing must be registered in the i-access risk management program.

Note Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Note Written applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

pomalidomide 3 mg capsule, 21

10406Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	10500.00	Pomalyst [CJ]

pomalidomide 4 mg capsule, 21

10387Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	10500.00	Pomalyst [CJ]

▪ RITUXIMAB

Note TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS
The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab), the T-cell co-stimulation modulator (abatacept) and the Janus-associated kinase (JAK) inhibitor (tofacitinib).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.
In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.
A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements: - a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and - once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.
For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270. A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.
(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.
(a) Initial treatment. Applications for initial treatment should be made where: (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).
Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.
Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab, tocilizumab and tofacitinib, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.
A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.
Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD. For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that where required an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.
Abatacept patients: Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the subcutaneous formulation, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.
Rituximab patients: A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.
(b) Continuing treatment. Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response. It is recommended that a patient be reviewed the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.
Rituximab patients: A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction. Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.
(2) Swapping therapy
Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non- bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.
Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.
A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.
Abatacept: Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.
Rituximab:In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.
To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment, within the timeframes specified in the relevant

HSD (Public)

restriction.
PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised bDMARD during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised bDMARD therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.
To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the prescription or remaining repeats for the bDMARD the patient is ceasing.
(3) Baseline measurements to determine response.
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be used for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be used to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.
Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (patient recommencing treatment after a break of more than 24 months)

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have severe active rheumatoid arthritis, **AND**
- Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**
- Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**
- Patient must not have failed previous PBS-subsidised treatment with rituximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR
- Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDS which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose,the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made at least 12 weeks after the first infusion so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services within 4 weeks of the date it was conducted. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient who fails to demonstrate a response to treatment with rituximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who fails to demonstrate a response to rituximab treatment and who qualifies to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response

Note The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:
(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;
(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**
- Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

HSD (Public)

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with rituximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised rituximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised rituximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response at least 12 weeks after the first infusion. This assessment must be submitted no later than 4 weeks from the date of the assessment.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient fails to demonstrate a response to a treatment with rituximab and who qualify to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a rheumatologist; OR
- Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Clinical criteria:

- Patient must have a documented history of severe active rheumatoid arthritis, **AND**
- Patient must have demonstrated an adequate response to treatment with this drug, **AND**
- Patient must have received this drug as the most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**
- Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**
- The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

- Patient must be aged 18 years or older.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab or tofacitinib.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

rituximab 500 mg/50 mL injection, 50 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9544H	1	..	..	1826.94	Mabthera [RO]

▪ THALIDOMIDE

Caution Thalidomide is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Note Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.

Authority required (STREAMLINED)

5914

Multiple myeloma

thalidomide 100 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9667T	2	..	..	*1596.00	Thalomid [CJ]

thalidomide 50 mg capsule, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9566L	4	..	..	*1596.00	Thalomid [CJ]

▪ MUSCULO-SKELETAL SYSTEM

▪ MUSCLE RELAXANTS

MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS

Other centrally acting agents

▪ BACLOFEN

Authority required (STREAMLINED)

7152

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity of cerebral origin.

Authority required (STREAMLINED)

7134

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to multiple sclerosis.

Authority required (STREAMLINED)

7153

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord injury.

Authority required (STREAMLINED)

7148

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord disease.

baclofen 40 mg/20 mL intrathecal injection, 20 mL ampoule

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11195F	2	..	..	*996.80	Sintetica Baclofen Intrathecal [BZ]

▪ BACLOFEN

Note Pharmaceutical benefits that have the form baclofen 10 mg/5 mL intrathecal injection, 5 mL ampoule and pharmaceutical benefits that have the form baclofen 10 mg/5 mL intrathecal injection, 10 x 5 mL ampoules are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

6925

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity of cerebral origin.

Authority required (STREAMLINED)

6939

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to multiple sclerosis.

Authority required (STREAMLINED)

6940

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord injury.

Authority required (STREAMLINED)

6911

Severe chronic spasticity

Clinical criteria:

- Patient must have failed to respond to treatment with oral antispastic agents; OR
- Patient must have had unacceptable side effects to treatment with oral antispastic agents, **AND**
- Patient must have chronic spasticity due to spinal cord disease.

baclofen 10 mg/5 mL intrathecal injection, 5 mL ampoule

5617P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
10	..	..	*1246.30	[a] Bacthecal [DZ]	[a] Lioresal Intrathecal [NV]

baclofen 10 mg/5 mL intrathecal injection, 10 x 5 mL ampoules

11126N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	1246.30	[a] Sintetica Baclofen Intrathecal [BZ]

▪ DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

▪ IBANDRONATE

Authority required (STREAMLINED)

5291

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

ibandronate 6 mg/6 mL injection, 6 mL vial

5750P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	11	..	324.29	Bondronat [RO]

▪ PAMIDRONATE DISODIUM

Authority required (STREAMLINED)

4433

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

pamidronate disodium 60 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5669J	1	2	..	55.26	Pamisol [PF]

pamidronate disodium 15 mg/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5667G	4	2	..	*55.24	Pamisol [PF]

pamidronate disodium 30 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5668H	2	2	..	*55.26	Pamisol [PF]

▪ PAMIDRONATE DISODIUM

Authority required (STREAMLINED)

4433

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

Authority required (STREAMLINED)

5218

Multiple myeloma

Authority required (STREAMLINED)

5291

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

pamidronate disodium 90 mg/10 mL injection, 10 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5670K	1	11	..	82.89	Pamisol [PF]

▪ ZOLEDRONIC ACID

Note Pharmaceutical benefits that have the form zoledronic acid 4 mg/100 mL injection and pharmaceutical benefits that have the form zoledronic acid 4 mg/5 mL injection are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

5735

Multiple myeloma

Authority required (STREAMLINED)

5605

Bone metastases

Clinical criteria:

- The condition must be due to breast cancer.

Authority required (STREAMLINED)

5703

Bone metastases

Clinical criteria:

- The condition must be due to castration-resistant prostate cancer.

Authority required (STREAMLINED)

5704

Hypercalcaemia of malignancy

Clinical criteria:

- Patient must have a malignancy refractory to anti-neoplastic therapy.

zoledronic acid 4 mg/100 mL injection, 100 mL bag

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10561W	1	11	..	245.33	[a] DBL Zoledronic Acid [PF]

zoledronic acid 4 mg/5 mL injection, 5 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
9653C	1	11	..	245.33	[a] APO-Zoledronic Acid [TX] [a] Zometa [NV]	[a] DBL Zoledronic Acid [PF]

zoledronic acid 4 mg/100 mL injection, 100 mL vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10548E	1	11	..	245.33	[a] Zometa [NV]

NERVOUS SYSTEM

ANTI-PARKINSON DRUGS

DOPAMINERGIC AGENTS

Dopa and dopa derivatives

LEVODOPA + CARBIDOPA ANHYDROUS

Note Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.

Authority required (STREAMLINED)

6863

Advanced Parkinson disease

Clinical criteria:

- Patient must have severe disabling motor fluctuations not adequately controlled by oral therapy, **AND**
- The treatment must be commenced in a hospital-based movement disorder clinic.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL intestinal gel, 7 x 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9743T	8	5	..	*11536.00	Duodopa [VE]

Dopamine agonists

APOMORPHINE

Authority required (STREAMLINED)

6813

Parkinson disease

Clinical criteria:

- Patient must have experienced severely disabling motor fluctuations which have not responded to other therapy.

apomorphine hydrochloride hemihydrate 100 mg/20 mL injection, 5 x 20 mL vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11093W	18	5	..	*7552.80	Apomine Solution for Infusion [PF]

APOMORPHINE

Authority required (STREAMLINED)

4833

Parkinson disease

Clinical criteria:

- Patient must have experienced severely disabling motor fluctuations which have not responded to other therapy.

apomorphine hydrochloride hemihydrate 50 mg/5 mL injection, 5 x 5 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5610G	36	5	..	*8168.04	Movapo [TD]

apomorphine hydrochloride hemihydrate 20 mg/2 mL injection, 5 x 2 mL ampoules

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5609F	72	5	..	*6528.96	Movapo [TD]

apomorphine hydrochloride hemihydrate 50 mg/10 mL injection, 5 x 10 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10950H	36	5	..	*8168.04	Movapo PFS [TD]

PSYCHOLEPTICS

ANTIPSYCHOTICS

Diazepines, oxazepines, thiazepines and oxepines

CLOZAPINE

Note Patients receiving clozapine under the PBS listing must be registered in the clozapine patient monitoring program relevant for the brand of clozapine being prescribed and dispensed: Novartis Clozaril Patient Monitoring System (eCPMS) or Hospira Clopineconnect.

Authority required (STREAMLINED)

5015

Schizophrenia

Treatment Phase: Initial treatment

Treatment criteria:

HSD (Public)

- Must be treated by a psychiatrist or in consultation with the psychiatrist affiliated with the hospital or specialised unit managing the patient.

Clinical criteria:

- Patient must be non-responsive to other neuroleptic agents; OR
- Patient must be intolerant of other neuroleptic agents.

Patients must complete at least 18 weeks of initial treatment under this restriction before being able to qualify for treatment under the continuing restriction.

The name of the consulting psychiatrist should be included in the patient's medical records.

A medical practitioner should request a quantity sufficient for up to one month's supply. Up to 5 repeats will be authorised.

clozapine 200 mg tablet, 100

5627E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*484.76	Clopine 200 [PF]

clozapine 25 mg tablet, 100

5628F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*64.64	[a] Clopine 25 [PF]	[a] Clozaril 25 [GO]

clozapine 100 mg tablet, 100

5629G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*242.38	[a] Clopine 100 [PF]	[a] Clozaril 100 [GO]

clozapine 50 mg/mL oral liquid, 100 mL

5630H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	135.00	Clopine Suspension [PF]

clozapine 50 mg tablet, 100

5626D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	2	..	..	*129.28	Clopine 50 [PF]

RESPIRATORY SYSTEM

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Other systemic drugs for obstructive airway diseases

MEPOLIZUMAB

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ, please contact GlaxoSmithKline Medical Information on 1800 033 109.

Note It is recommended that an application for continuing treatment is submitted at the time of the 26 to 30 week assessment, to ensure continuity of treatment for those patients who meet the continuation criteria for PBS-subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE EOSINOPHILIC ASTHMA
Patients are eligible to commence a 'mepolizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to mepolizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised mepolizumab therapy before they are eligible to commence the next mepolizumab treatment cycle, or if eligible, an 'omalizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised mepolizumab is stopped to the date of the first application for initial treatment with mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised mepolizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised mepolizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with mepolizumab following a break in PBS-subsidised therapy of more than 6 months; or
iii) A patient has received prior PBS-subsidised omalizumab and wishes to commence treatment with mepolizumab after a

treatment break of 6 months.
All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 32 weeks of therapy for mepolizumab.
(b) Grandfather patients:
For patients who commenced treatment with mepolizumab for uncontrolled severe eosinophilic asthma prior to 1 January 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with mepolizumab will be authorised under this criterion. Approval will be based on the criteria included in the relevant restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with mepolizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with mepolizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with mepolizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing mepolizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted with the Initial authority application for mepolizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent mepolizumab treatment cycle, or an initial omalizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must be under the care of the same physician for at least 12 months, **AND**
- Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 1 or more occasions in the previous 12 months, **AND**
- Patient must have blood eosinophil count greater than or equal to 300 cells per microlitre in the last 6 weeks, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, AND

(b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) assessment of the patient must be made at time of application for treatment (to establish baseline score) and again around 26 to 30 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment at around 26 to 30 weeks, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab or omalizumab within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request 7 repeats to provide for an initial course of mepolizumab sufficient for 32 weeks of therapy.

Mepolizumab and omalizumab may not be used concurrently or within 6 months of each other. A patient is required to have ceased treatment with omalizumab for 6 months prior to initiating treatment with mepolizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Initial PBS Authority Application - Supporting Information Form,

which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) a copy of the eosinophil pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

mepolizumab 100 mg injection, 1 vial

10996R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	7	..	1638.00	Nucala [GK]

▪ MEPOLIZUMAB

Note For copies of the ACQ, please contact GlaxoSmithKline Medical Information on 1800 033 109.

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE EOSINOPHILIC ASTHMA

Patients are eligible to commence a 'mepolizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.

Once a patient has either failed to achieve or maintain a response to mepolizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised mepolizumab therapy before they are eligible to commence the next mepolizumab treatment cycle, or if eligible, an 'omalizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised mepolizumab is stopped to the date of the first application for initial treatment with mepolizumab under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised mepolizumab therapy:

(a) Initial treatment:

Applications for initial treatment should be made where:

i) A patient has received no prior PBS-subsidised mepolizumab treatment and wishes to commence such therapy; or

ii) A patient wishes to recommence treatment with mepolizumab following a break in PBS-subsidised therapy of more than 6 months; or

iii) A patient has received prior PBS-subsidised omalizumab and wishes to commence treatment with mepolizumab after a treatment break of 6 months.

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 32 weeks of therapy for mepolizumab.

(b) Grandfather patients:

For patients who commenced treatment with mepolizumab for uncontrolled severe eosinophilic asthma prior to 1 January 2017 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with mepolizumab will be authorised under this criterion. Approval will be based on the criteria included in the relevant restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with mepolizumab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.

HSD (Public)

(c) Continuing treatment:
Following the completion of the initial treatment course with mepolizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with mepolizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing mepolizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted with the Initial authority application for mepolizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent mepolizumab treatment cycle, or an initial omalizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

Note No increase in the maximum quantity or number of units may be authorised.

Note No increase in the maximum number of repeats may be authorised.

Note Special Pricing Arrangements apply.

HSD (Public)

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have demonstrated or sustained an adequate response to PBS-subsidised treatment with this drug, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

An adequate response to mepolizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline,

OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline.

All applications for continuing treatment with mepolizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, and the assessment of oral corticosteroid dose, must be made at around 26 to 30weeks after the first dose of PBS-subsidised mepolizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with mepolizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of repeats to provide for a continuing course of mepolizumab sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Continuing PBS Authority Application - Supporting Information Form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note It is recommended that second and subsequent applications for continuing treatment are submitted at the time of an 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criteria for PBS-subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Uncontrolled severe eosinophilic asthma

Treatment Phase: Initial treatment - grandfather patients

Clinical criteria:

- Patient must have received non-PBS treatment with this drug for this condition prior to 1 January 2017, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have had, prior to commencement of mepolizumab, a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) Forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or(ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or(iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have had blood eosinophil count greater than or equal to 300 cells per microlitre prior to commencement of mepolizumab, **AND**
- Patient must have had a duration of asthma of at least 1 year prior to commencement of mepolizumab, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy prior to mepolizumab therapy despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have demonstrated an adequate response to treatment with mepolizumab, **AND**
- The treatment must not be used in combination with omalizumab.

Population criteria:

- Patient must be aged 12 years or older.

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

A review of the patient's records should be conducted to extract pre- and post-mepolizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Parameters to establish response are: (i) a reduction in Asthma Control Questionnaire (ACQ-5) score of at least 0.5; and/or(ii) maintenance oral corticosteroid dose reduced by at least 25% from baseline.

The assessment of the patient's response to the initial PBS subsidised course of treatment must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed. The same parameters used to establish response to non-PBS-subsidised therapy with mepolizumab should be used for the assessment.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with mepolizumab.

Patients will be eligible to receive continuing courses of mepolizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

A patient who fails to respond to a course of PBS-subsidised mepolizumab for the treatment of uncontrolled severe eosinophilic asthma will not be eligible to receive further PBS-subsidised treatment with mepolizumab or omalizumab within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for a continuing course of mepolizumab sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Eosinophilic Asthma Grandfather PBS Authority Application - Supporting Information Form, which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of pre- and post-mepolizumab data on symptoms, quality of life, medication doses, severe exacerbation/s and hospitalisations, and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) a copy of the pre-mepolizumab eosinophil pathology report.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS subsidised mepolizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

mepolizumab 100 mg injection, 1 vial

10980X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	1638.00	Nucala [GK]

HSD (Public)

▪ OMALIZUMAB

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

Clinical criteria:

- The condition must be based on both physical examination and patient history (to exclude any factors that may be triggering the urticaria), **AND**
- Patient must have experienced itch and hives that persist on a daily basis for at least 6 weeks despite treatment with H1 antihistamines, **AND**
- Patient must have failed to achieve an adequate response after a minimum of 2 weeks treatment with a standard therapy, **AND**
- Patient must not receive more than 12 weeks of treatment under this restriction.

A standard therapy is defined as a combination of therapies that includes H1 antihistamines at maximally tolerated doses in accordance with clinical guidelines, and one of the following:

1) a H2 receptor antagonist (150 mg twice per day); or

2) a leukotriene receptor antagonist (LTRA) (10 mg per day); or

3) doxepin (up to 25 mg three times a day)

If the requirement for treatment with H1 antihistamines and a H2 receptor antagonist, or a leukotriene receptor antagonist or doxepin cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

A failure to achieve an adequate response to standard therapy is defined as a current Urticaria Activity Score 7 (UAS7) score of equal to or greater than 28 with an itch score of greater than 8, as assessed while still on standard therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Spontaneous Urticaria Omalizumab Initial PBS Authority Application - Supporting Information Form which must include:

(i) demonstration of failure to achieve an adequate response to standard therapy; and

(ii) drug names and doses of standard therapies that the patient has failed; and

(iii) a signed patient acknowledgment that cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

omalizumab 150 mg/mL injection, 1 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11176F	2	2	..	*820.00	Xolair [NV]

▪ OMALIZUMAB

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

Clinical criteria:

- Patient must have demonstrated a response to the most recent PBS-subsidised treatment with this drug for this condition, **AND**
- Patient must not receive more than 24 weeks per authorised course of treatment under this restriction.

Note A proportion of patients respond to 150 mg 4-weekly so where a substantial improvement has been obtained with a 300 mg dose it is reasonable to back-titrate dose after initial treatment.

Note Cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

Note Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Authority required

Severe chronic spontaneous urticaria

Treatment Phase: Grandfathering treatment

Clinical criteria:

- Patient must have received non-PBS subsidised treatment with this drug for this condition prior to 1 September 2017, **AND**
- Patient must have documented history of itch and hives that persisted on a daily basis for at least 6 weeks despite treatment with H1 antihistamines prior to commencing non-PBS subsidised treatment with this drug for this condition, **AND**
- Patient must have documented history of failure to achieve an adequate response after a minimum of 2 weeks treatment with a standard therapy prior to commencing non-PBS subsidised treatment with this drug for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a clinical immunologist; OR
- Must be treated by an allergist; OR
- Must be treated by a dermatologist; OR
- Must be treated by a general physician with expertise in the management of chronic spontaneous urticaria (CSU).

A standard therapy is defined as a combination of therapies that includes H1 antihistamines at maximally tolerated doses in accordance with clinical guidelines, and one of the following:

1) a H2 receptor antagonist (150 mg twice per day); or

2) a leukotriene receptor antagonist (LTRA) (10 mg per day); or

3) doxepin (up to 25 mg three times a day)

If the requirement for treatment with H1 antihistamines and a H2 receptor antagonist, or a leukotriene receptor antagonist or doxepin cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

A failure to achieve an adequate response to standard therapy is defined as a current Urticaria Activity Score 7 (UAS7) score of equal to or greater than 28 with an itch score of greater than 8, as assessed while still on standard therapy.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Spontaneous Urticaria Omalizumab Initial Grandfather PBS Authority Application - Supporting Information Form which must include:

(i) demonstration of failure to achieve an adequate response to standard therapy; and

(ii) drug names and doses of standard therapies that the patient has failed; and

(iii) a signed patient acknowledgment that cessation of therapy should be considered after the patient has demonstrated clinical benefit with omalizumab to re-evaluate the need for continued therapy. Any patient who ceases therapy and whose CSU relapses will need to re-initiate PBS-subsidised omalizumab as a new patient.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

omalizumab 150 mg/mL injection, 1 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
11168T	2	5	..	*820.00	Xolair [NV]

▪ OMALIZUMAB

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a diagnosis of asthma confirmed and documented by a paediatric respiratory physician, clinical immunologist, or allergist; or paediatrician or general physician experienced in the management of patients with severe asthma in consultation with a respiratory physician, defined by the following standard clinical features: forced expiratory volume (FEV1) reversibility or airway hyperresponsiveness or peak expiratory flow (PEF) variability, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or an in vitro measure of specific IgE, **AND**
- Patient must have total serum human immunoglobulin E greater than or equal to 30 IU/mL, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

- Patient must be aged 6 to less than 12 years.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must be under the care of the same physician for at least 6 months.

Optimised asthma therapy includes:

(i) Adherence to optimal inhaled therapy, including high dose inhaled corticosteroid (ICS) and long-acting beta-2 agonist (LABA) therapy for at least six months. If LABA therapy is contraindicated, not tolerated or not effective, montelukast, cromoglycate or nedocromil may be used as an alternative; AND

(ii) treatment with at least 2 courses of oral or IV corticosteroids (daily or alternate day maintenance treatment courses, or 3-5 day exacerbation treatment courses), in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications (including those specified in the relevant TGA-approved Product Information) and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The initial IgE assessment must be no more than 12 months old at the time of application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) An Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month (for children aged 6 to 10 years it is recommended that the Interviewer Administered version - the ACQ-IA be used), AND

(b) while receiving optimised asthma therapy in the previous 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) or ACQ-IA assessment of the patient's response to this initial course of treatment, the assessment of oral corticosteroid dose, and the assessment of exacerbation rate must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab of up to 28 weeks, consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Severe Allergic Asthma Initial PBS Authority Application - Supporting Information form, which includes the following:

(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) acknowledgement signed by a parent or authorised guardian; and

(c) a copy of the IgE pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) or the Asthma Control Questionnaire interviewer administered version (ACQ-IA) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the prescriber's signature.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA

Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy.
(a) Initial treatment:
Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.
(b) Grandfather patients:
Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December 2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic

HSD (Public)

reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe allergic asthma, **AND**
- Patient must have demonstrated or sustained an adequate response to treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

An adequate response to omalizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) or ACQ-IA score of at least 0.5 from baseline, OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 or ACQ-IA score from baseline, OR

(c) a reduction in the time-adjusted exacerbation rates compared to the 12 months prior to baseline.

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) or Asthma Control Questionnaire interviewer administered version (ACQ-IA) assessment of the patient's response to the prior course of treatment, the assessment of systemic corticosteroid dose, and the assessment of time-adjusted exacerbation rate must be made at around 18 to 22 weeks after the first dose of PBS-subsidised omalizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Severe Allergic Asthma Continuing PBS Authority Application - Supporting Information form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) or the Asthma Control Questionnaire interviewer administered version (ACQ-IA) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the signature of the prescriber.

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note **TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA**
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy.
(a) Initial treatment:

HSD (Public)

Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.
(b) Grandfather patients:
Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December 2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial and continuing treatment - balance of supply

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment; OR
- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction or Grandfather treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the Initial restriction or up to 24 weeks treatment available under the Continuing or Grandfather restrictions.

Note Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment under the initial restriction or 24 weeks of treatment under the continuing or grandfather restrictions may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

- Patient must have previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 December 2016, **AND**
- Patient must be receiving treatment with this drug for this condition at the time of application, **AND**
- Patient must have had, prior to commencement of omalizumab, a diagnosis of asthma confirmed and documented by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the

HSD (Public)

management of patients with severe asthma, in consultation with a respiratory physician, defined by the following standard clinical features: forced expiratory volume (FEV1) reversibility or airway hyperresponsiveness or peak expiratory flow (PEF) variability, **AND**

- Patient must have had a duration of asthma of at least 1 year prior to commencement of omalizumab, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or an in vitro measure of specific IgE, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy prior to omalizumab therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- Patient must have demonstrated an adequate response to treatment.

Population criteria:

- Patient must be aged 6 to less than 12 years.

Treatment criteria:

- Must be treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician.

Clinical criteria:

- Patient must be under the care of the same physician for at least 6 months.

Optimised asthma therapy includes:

(i) Adherence to optimal inhaled therapy, including high dose inhaled corticosteroid (ICS) and long-acting beta-2 agonist (LABA) therapy for at least six months. If LABA therapy is contraindicated, not tolerated or not effective, montelukast, cromoglycate or nedocromil may be used as an alternative; AND

(ii) treatment with at least 2 courses of oral or IV corticosteroids (daily or alternate day maintenance treatment courses, or 3-5 day exacerbation treatment courses), in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications (including those specified in the relevant TGA-approved Product Information) and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

A review of the patient's records should be conducted to extract pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Examples of parameters to establish response include:

(i) a reduction in Asthma Control Questionnaire (ACQ-5) or Asthma Control Questionnaire Interviewer Administered (ACQ-IA) score of at least 0.5;

(ii) maintenance oral corticosteroid dose reduced by at least 25% from baseline; and/or

(iii) a reduction in the number of hospitalisations or severe exacerbations requiring use of systemic corticosteroids, compared to the 12 months prior to commencement of omalizumab.

The assessment of the patient's response to the initial PBS subsidised course of treatment must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed. The same parameters used to establish response to non-PBS-subsidised therapy with omalizumab should be used for the assessment.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

Patients will be eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

Patients may qualify for PBS-subsidised treatment under this restriction once only.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for an initial course of omalizumab of up to 24 weeks, consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Paediatric Grandfather Severe Allergic Asthma PBS Authority Application - Supporting Information Form, which includes the following:

(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and

(ii) details of pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations; and

(iii) acknowledgement signed by a parent or authorised guardian.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

Note For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available

HSD (Public)

on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF PAEDIATRIC PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA

Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy.
(a) Initial treatment:
Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy for omalizumab.
(b) Grandfather patients:
Paediatric patients who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 December 2016 and who continue to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction. A patient may only qualify for PBS-subsidised treatment under this restriction once. A maximum of 24 weeks of treatment with omalizumab will be authorised under this restriction. Approval will be based on the criteria included in the grandfather restriction. Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). If a 'Grandfathered' patient recommences on second and subsequent cycles after a treatment break, the 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' below for further details.
(c) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or ACQ-IA, systemic corticosteroid dose and time-adjusted exacerbation rate, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and The Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (systemic corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score or ACQ-IA, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

omalizumab 150 mg/mL injection, 1 mL syringe

10973M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	410.00	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 0.5 mL syringe

10967F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	..	..	205.00	Xolair [NV]

▪ OMALIZUMAB

Note Special Pricing Arrangements apply.

Authority required

Uncontrolled severe allergic asthma
Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must be under the care of the same physician for at least 12 months, **AND**
- Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**
- Patient must have a duration of asthma of at least 1 year, **AND**
- Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 1 or more occasions in the previous 12 months, **AND**
- Patient must have past or current evidence of atopy, documented by skin prick testing or RAST, **AND**
- Patient must have total serum human immunoglobulin E greater than or equal to 30 IU/mL, **AND**
- Patient must have signed a patient or parent/guardian acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**
- Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**
- Patient must not receive more than 28 weeks of treatment under this restriction, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised mepolizumab.

Population criteria:

- Patient must be aged 12 years or older.

Optimised asthma therapy includes:

(i) Adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (ICS) plus long-acting beta-2 agonist (LABA) therapy for at least 12 months, unless contraindicated or not tolerated; AND

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the Authority application.

The initial IgE assessment must be no more than 12 months old at the time of application.

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, AND

(b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician.

The Asthma Control Questionnaire (5 item version) assessment of the patient's response to this initial course of treatment, and the assessment of oral corticosteroid dose, must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab or mepolizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form,

which includes the following:

(i) details of prior optimised asthma drug therapy (date of commencement and duration of therapy); and

(ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and

(iii) the signed patient or parent/guardian acknowledgement; and

(c) the IgE pathology report; and

(d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

HSD (Public)

Note For copies of the ACQ and the calculation sheets please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next omalizumab treatment cycle or, if eligible, a 'mepolizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab or mepolizumab treatment is stopped to the date of the first application for initial treatment with omalizumab or mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised omalizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with omalizumab following a break in PBS-subsidised therapy of at least 6 months; or
iii) A patient has received prior PBS-subsidised mepolizumab and wishes to commence treatment with omalizumab after a treatment break of at least 6 months.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy of omalizumab.
(b) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or oral corticosteroid dose submitted with the Initial authority application for omalizumab. For patients transitioned from the paediatric to the adolescent/adult restriction, the exacerbation history may also be used to determine response. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent omalizumab treatment cycle, or an initial mepolizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - balance of supply

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restriction.

HSD (Public)

Note Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have a documented history of severe allergic asthma, **AND**
- Patient must have demonstrated or sustained an adequate response to PBS-subsidised treatment with this drug, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must not be used in combination with, or within 6 months of treatment with, PBS-subsidised mepolizumab.

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Population criteria:

- Patient must be aged 12 years or older.

An adequate response to omalizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline, OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline, OR

(c) a reduction in the time-adjusted exacerbation rates compared to the 12 months prior to baseline (this criterion is only applicable for patients transitioned from the paediatric to the adolescent/adult restriction).

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, the assessment of oral corticosteroid dose, and the assessment of time adjusted exacerbation rate must be made at around 18 to 22 weeks after the first dose of PBS-subsidised omalizumab so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form(s); and

(b) a completed Severe Allergic Asthma PBS Authority Application and Supporting Information Form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms and is endorsed with the signature of the prescriber; for patients transitioned from the paediatric to the adolescent/adult restrictions an exacerbation calculation sheet may be submitted.

Note If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

Note For copies of the ACQ and the calculation sheets please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

Note It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Note **TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA**
Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.
Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a

HSD (Public)

treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next omalizumab treatment cycle or, if eligible, a 'mepolizumab treatment cycle'. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab or mepolizumab treatment is stopped to the date of the first application for initial treatment with omalizumab or mepolizumab under the new treatment cycle.
There is no limit to the number of treatment cycles a patient may undertake in their lifetime.
(1) How to prescribe PBS-subsidised omalizumab therapy:
(a) Initial treatment:
Applications for initial treatment should be made where:
i) A patient has received no prior PBS-subsidised omalizumab treatment and wishes to commence such therapy; or
ii) A patient wishes to recommence treatment with omalizumab following a break in PBS-subsidised therapy of at least 6 months; or
iii) A patient has received prior PBS-subsidised mepolizumab and wishes to commence treatment with omalizumab after a treatment break of at least 6 months.
All applications for initial treatment for non-grandfathered patients will be limited to provide for a maximum of 28 weeks of therapy of omalizumab.
(b) Continuing treatment:
Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.
(2) Baseline measurements to determine response:
The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) or oral corticosteroid dose submitted with the Initial authority application for omalizumab. For patients transitioned from the paediatric to the adolescent/adult restriction, the exacerbation history may also be used to determine response. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.
(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:
A patient who wishes to trial a second or subsequent omalizumab treatment cycle, or an initial mepolizumab treatment cycle, following a break in PBS-subsidised therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.
(4) Monitoring of patients:
Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Note Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment - balance of supply

Treatment criteria:

- Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Clinical criteria:

- Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**
- The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Note Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

omalizumab 150 mg/mL injection, 1 mL syringe

10109C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	410.00	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 0.5 mL syringe

10118M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
	1	..	..	205.00	Xolair [NV]

HSD (Public)

COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Mucolytics

DORNASE ALFA

Note It is highly desirable that all patients be included in the national cystic fibrosis patient database.

Authority required (STREAMLINED)

5740

Cystic fibrosis

Population criteria:

- Patient must be 5 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with dornase alfa at a dose of 2.5 mg daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required (STREAMLINED)

5634

Cystic fibrosis

Clinical criteria:

- Patient must have a severe clinical course with frequent respiratory exacerbations or chronic respiratory symptoms (including chronic or recurrent cough, wheeze or tachypnoea) requiring hospital admissions more frequently than 3 times per year; OR
- Patient must have significant bronchiectasis on chest high resolution computed tomography scan; OR
- Patient must have severe cystic fibrosis bronchiolitis with persistent wheeze non-responsive to conventional medicines; OR
- Patient must have severe physiological deficit measure by forced oscillation technique or multiple breath nitrogen washout and failure to respond to conventional therapy.

Population criteria:

- Patient must be less than 5 years of age.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Following an initial 6 months therapy, a comprehensive assessment must be undertaken and documented. Treatment with this drug should cease if there is not agreement of benefit, as there is always the possibility of harm from unnecessary use. Further reassessments must be undertaken and documented at six-monthly intervals.

Authority required (STREAMLINED)

5635

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have initiated treatment with dornase alfa at an age of less than 5 years, **AND**
- Patient must have undergone a comprehensive assessment which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

- Patient must be 5 years of age or older.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with this drug should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

dornase alfa 2.5 mg/2.5 mL inhalation solution, 30 x 2.5 mL ampoules

5704F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
2	5	..	*2242.00	Pulmozyme [RO]

MANNITOL

Note It is highly desirable that all patients be included in the national cystic fibrosis patient database.

Authority required (STREAMLINED)

7362

Cystic fibrosis

Clinical criteria:

- The treatment must be as monotherapy, **AND**
- Patient must be intolerant or inadequately responsive to dornase alfa.

Population criteria:

- Patient must be 6 years of age or older.

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information initiation dose assessment for this drug, prior to therapy with this drug, with a negative result.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required (STREAMLINED)

7367

Cystic fibrosis

Clinical criteria:

- The treatment must be in combination with dornase alfa, **AND**
- Patient must be inadequately responsive to dornase alfa, **AND**
- Patient must have trialled hypertonic saline for this condition.

Population criteria:

- Patient must be 6 years of age or older.

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information initiation dose assessment for this drug, prior to therapy with this drug, with a negative result.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis or by a specialist physician or paediatrician in consultation with such a unit.

Prior to therapy with this drug, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

To be eligible for continued PBS-subsidised treatment with this drug following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) and the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments must be undertaken and documented at six-monthly intervals. Therapy with this drug should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers, 1

2015C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
4	5	..	*1736.00	bronchitol [XA]

OTHER RESPIRATORY SYSTEM PRODUCTS

OTHER RESPIRATORY SYSTEM PRODUCTS

Other respiratory system products

IVACAFTOR

Note Special Pricing Arrangements apply.

Note No increase in the maximum number of repeats may be authorised.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - New patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and

(3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and

(5) the result of a FEV1 measurement performed within a month prior to the date of application, if aged from 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(6) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(7) a copy of a sweat chloride result; and

(8) height and weight measurements at the time of application; and

(9) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem,

HSD (Public)

erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and

(3) the result of a FEV1 measurement performed within one month prior to the date of application, if aged 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(5) height and weight measurements at the time of application; and

(6) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

ivacaftor 150 mg tablet, 56

10170G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	22500.00	Kalydeco [VR]

HSD (Public)

▪ IVACAFTOR

Note Special Pricing Arrangements apply.

Note No increase in the maximum number of repeats may be authorised.

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - New patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and

(3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and

(5) the result of a FEV1 measurement performed within a month prior to the date of application, if aged from 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(6) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(7) a copy of a sweat chloride result; and

(8) height and weight measurements at the time of application; and

(9) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be aged 2 years or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole. Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one tablet (150 mg) or one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets or sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and

(3) the result of a FEV1 measurement performed within one month prior to the date of application, if aged 6 years or older. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and

(4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(5) height and weight measurements at the time of application; and

(6) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

- Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**
- Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR
- Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**
- Patient must have received treatment with ivacaftor for this condition prior to 1 May 2017, **AND**
- Patient must have received treatment with ivacaftor within the last 6 months at the time of application, **AND**
- Patient must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis, **AND**
- Patient must not receive more than 24 weeks of treatment under this restriction, **AND**
- The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

- Patient must be 2 to 5 years of age.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of one sachet twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 sachets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of one sachet once daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil. Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 sachets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, rufinamide.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

The authority application must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Cystic Fibrosis Ivacaftor Application Supporting Information Form; and

(3) an acknowledgement signed by a parent, or authorised guardian if applicable; and

(4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene performed prior to commencing treatment with ivacaftor; and

(5) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and

(6) a copy of sweat chloride result performed prior to commencing treatment with ivacaftor for this condition; and

(7) height and weight measurements at the time of application; and

(8) height and weight measurements performed immediately prior to commencement of ivacaftor; and

(9) a baseline measurement of number of days of CF-related hospitalisation (including hospital-in-the home) in the 12 months prior to commencement of ivacaftor; and

(10) a measurement of the number of days of CF-related hospitalisation (including hospital-in the home) in the 6 months prior to the date of application; and

(11) dates of prior ivacaftor therapy.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs
Reply Paid 9826
HOBART TAS 7001

ivacaftor 75 mg granules, 4 x 14 sachets

11098D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	22500.00	Kalydeco [VR]

ivacaftor 50 mg granules, 4 x 14 sachets

11105L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
1	5	..	22500.00	Kalydeco [VR]

VARIOUS

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Iron chelating agents

DEFERASIROX

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6420

Chronic iron overload

Clinical criteria:

- Patient must have a disorder of erythropoiesis.

deferasirox 125 mg dispersible tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5654N	6	5	..	*1331.40	Exjade [NV]

deferasirox 500 mg dispersible tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5656Q	6	5	..	*5325.54	Exjade [NV]

deferasirox 250 mg dispersible tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5655P	6	5	..	*2662.74	Exjade [NV]

DEFERIPRONE

Authority required (STREAMLINED)

6448

Iron overload

Clinical criteria:

- Patient must have thalassaemia major, **AND**
- Patient must be unable to take desferrioxamine therapy.

Authority required (STREAMLINED)

6403

Iron overload

Clinical criteria:

- Patient must have thalassaemia major, **AND**
- Patient must be one in whom desferrioxamine therapy has proven ineffective.

deferiprone 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5657R	6	5	..	*2568.18	Ferriprox [TX]

deferiprone 100 mg/mL oral liquid, 250 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5658T	5	5	..	*1070.10	Ferriprox [TX]

DESFERRIOXAMINE

Authority required (STREAMLINED)

6394

Disorders of erythropoiesis

Clinical criteria:

- The condition must be associated with treatment-related chronic iron overload.

desferrioxamine mesilate 500 mg injection, 10 vials

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5662B	40	5	..	*4254.80	Hospira Pty Limited [PF]

desferrioxamine mesilate 2 g injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5661Y	60	5	..	*1868.40	Hospira Pty Limited [PF]

Drugs for treatment of hyperkalemia and hyperphosphatemia

▪ LANTHANUM

Authority required (STREAMLINED)

5530

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5782H	2	5	..	*845.52	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5781G	2	5	..	*751.04	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
5780F	2	5	..	*497.36	Fosrenol [ZI]

▪ SEVELAMER

Authority required (STREAMLINED)

5530

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

sevelamer hydrochloride 800 mg tablet, 180

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
9546K	2	5	..	*589.00	Renagel [GZ]

▪ SUCROFERRIC OXYHYDROXIDE

Authority required (STREAMLINED)

5530

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

- The condition must not be adequately controlled by calcium, **AND**
- Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR
- The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**
- The treatment must not be used in combination with any other non-calcium phosphate binding agents.

Treatment criteria:

- Patient must be undergoing dialysis for chronic kidney disease.

iron (as sucroferric oxyhydroxide) 500 mg tablet: chewable, 90

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	Brand Name and Manufacturer
10233N	2	5	..	*753.46	Velphoro [FN]

Highly Specialised Drugs Program (Community Access)

ANTIINFECTIVES FOR SYSTEMIC USE 1233

ANTIVIRALS FOR SYSTEMIC USE 1233
DIRECT ACTING ANTIVIRALS 1233

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 1250

IMMUNOSTIMULANTS 1250
IMMUNOSTIMULANTS 1250

NERVOUS SYSTEM 1251

PSYCHOLEPTICS 1251
ANTIPSYCHOTICS 1251

ANTIINFECTIVES FOR SYSTEMIC USE

ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

GANCICLOVIR

Authority required (STREAMLINED)

5000

Cytomegalovirus retinitis

Clinical criteria:

- Patient must be severely immunocompromised, inculding due to HIV infection.

ganciclovir 500 mg injection, 5 vials

10328N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*560.43	39.50	Cymevene [RO]

VALGANCICLOVIR

Authority required (STREAMLINED)

4980

Cytomegalovirus retinitis

Clinical criteria:

- Patient must have HIV infection.

valganciclovir 50 mg/mL powder for oral liquid, 100 mL

10277X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	11	5	..	*#4396.02	39.50	Valcyte [RO]

valganciclovir 450 mg tablet, 60

10306K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*3631.45	39.50	[a] Valcyte [RO] [a] Valganciclovir Juno [JU] [a] Valganciclovir Sandoz [SZ]	[a] Valganciclovir AN [EA] [a] Valganciclovir Mylan [AF]

Protease inhibitors

ATAZANAVIR

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

atazanavir 150 mg capsule, 60

10276W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1038.43	39.50	Reyataz [BQ]

atazanavir 300 mg capsule, 30

10321F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1038.43	39.50	Reyataz [BQ]

atazanavir 200 mg capsule, 60

10349Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1369.33	39.50	Reyataz [BQ]

ATAZANAVIR + COBICISTAT

Authority required (STREAMLINED)

4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

atazanavir 300 mg + cobicistat 150 mg tablet, 30

10692R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1116.57	39.50	Evotaz [BQ]

▪ DARUNAVIR

Authority required (STREAMLINED)
5094
Human immunodeficiency virus (HIV) infection
Clinical criteria:
- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- The treatment must be co-administered with 100 mg ritonavir twice daily, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after at least one antiretroviral regimen.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

darunavir 150 mg tablet, 240

10287K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	1043.27	39.50	Prezista [JC]

darunavir 600 mg tablet, 60

10329P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*2039.69	39.50	Prezista [JC]

▪ DARUNAVIR

Authority required (STREAMLINED)
4313
Human immunodeficiency virus (HIV) infection
Clinical criteria:
- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- The treatment must be co-administered with 100 mg ritonavir, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after at least one antiretroviral regimen, **AND**
- Patient must not have demonstrated darunavir resistance associated mutations detected on resistance testing.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

darunavir 800 mg tablet, 30

10367P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1375.51	39.50	Prezista [JC]

▪ FOSAMPRENAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

fosamprenavir 700 mg tablet, 60

10337C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*756.37	39.50	Telzir [VI]

▪ INDINAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

indinavir 400 mg capsule, 180

10363K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*906.23	39.50	Crixivan 400 mg [MK]

▪ RITONAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

ritonavir 100 mg tablet, 30

10273Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	24	5	..	*978.19	39.50	Norvir [VE]

ritonavir 600 mg/7.5 mL oral liquid, 90 mL

10300D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	5	..	*906.25	39.50	Norvir [VE]

▪ SAQUINAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

saquinavir 500 mg tablet, 120

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10335Y	2	5	..	*1006.13	39.50	Invirase [RO]

▪ TIPRANAVIR

Authority required (STREAMLINED)

5764

HIV infection

Clinical criteria:

- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must be antiretroviral experienced, **AND**
- The treatment must be co-administered with 200 mg ritonavir twice daily, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after each of at least 3 different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

tipranavir 250 mg capsule, 120

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10344K	2	5	..	*1675.07	39.50	Aptivus [BY]

HSD (Community)

Nucleoside and nucleotide reverse transcriptase inhibitors

▪ ABACAVIR

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

abacavir 300 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10294T	2	5	..	*564.39	39.50	Ziagen [VI]

abacavir 20 mg/mL oral liquid, 240 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10356C	8	5	..	*656.35	39.50	Ziagen [VI]

▪ ADEFOVIR DIPIVOXIL

Note Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

Authority required (STREAMLINED)

4490

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have failed antihepadnaviral therapy, **AND**
- Patient must have repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration, in conjunction with documented chronic hepatitis B infection; OR
- Patient must have repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months whilst on previous antihepadnaviral therapy, except in patients with evidence of poor compliance.

Authority required (STREAMLINED)

4510
Chronic hepatitis B infection
Clinical criteria:
- Patient must have cirrhosis, **AND**
- Patient must have failed antihepadnaviral therapy, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

adefovir dipivoxil 10 mg tablet, 30

10290N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*1097.15	39.50	[a] APO-Adefovir [TX]	[a] Hepsera [GI]

▪ DIDANOSINE

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

didanosine 400 mg enteric capsule, 30

10313T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*652.89	39.50	Videx EC [BQ]

didanosine 250 mg enteric capsule, 30

10364L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*410.73	39.50	Videx EC [BQ]

▪ EMTRICITABINE

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

emtricitabine 200 mg capsule, 30

10274R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*564.39	39.50	Emtriva [GI]

▪ ENTECAVIR

Authority required (STREAMLINED)
4993
Chronic hepatitis B infection
Clinical criteria:
- Patient must not have cirrhosis, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR

- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by confirmed elevated serum ALT or liver biopsy.

Authority required (STREAMLINED)

5036

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

entecavir monohydrate 500 microgram tablet, 30

10279B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*645.05	39.50	[a] Baraclude [BQ] [a] Entecavir Amneal [EA] [a] Entecavir GH [GQ] [a] ENTECAVIR RBX [RA] [a] ENTECLUDE [RW]	[a] ENTAC [LR] [a] Entecavir APOTEX [TX] [a] Entecavir Mylan [AF] [a] Entecavir Sandoz [SZ]

▪ ENTECAVIR

Note PBS-subsidised entecavir monohydrate must be used as monotherapy.

Authority required (STREAMLINED)

5044

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have failed lamivudine, **AND**
- Patient must have repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration, in conjunction with documented chronic hepatitis B infection; OR
- Patient must have repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months whilst on previous antihepadnaviral therapy, except in patients with evidence of poor compliance.

Authority required (STREAMLINED)

5037

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have failed lamivudine, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

entecavir monohydrate 1 mg tablet, 30

10353X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
2	5	..	*1044.55	39.50	[a] Baraclude [BQ] [a] Entecavir Amneal [EA] [a] Entecavir GH [GQ] [a] ENTECAVIR RBX [RA] [a] ENTECLUDE [RW]	[a] ENTAC [LR] [a] Entecavir APOTEX [TX] [a] Entecavir Mylan [AF] [a] Entecavir Sandoz [SZ]

▪ LAMIVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

lamivudine 10 mg/mL oral liquid, 240 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10320E	8	5	..	*472.91	39.50	3TC [VI]

lamivudine 150 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10348P	2	5	..	*143.41	39.50	[a] 3TC [VI]	[a] Lamivudine Alphapharm [AF]

lamivudine 300 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10311Q	2	5	..	*143.41	39.50	[a] 3TC [VI]	[a] Lamivudine Alphapharm [AF]

▪ LAMIVUDINE

Authority required (STREAMLINED)

4993

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR
- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by confirmed elevated serum ALT or liver biopsy.

Authority required (STREAMLINED)

5036

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

lamivudine 100 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10315X	2	5	..	*80.55	39.50	[a] Zetlam [AF]
			[B] 1.20	*81.75	39.50	[a] Zeffix [RW]

lamivudine 5 mg/mL oral liquid, 240 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10338D	5	5	..	*242.45	39.50	Zeffix [RW]

▪ STAVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

stavudine 30 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10271N	2	5	..	*666.51	39.50	Zerit [BQ]

stavudine 40 mg capsule, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10312R	2	5	..	*886.29	39.50	Zerit [BQ]

▪ TENOFOVIR

Note Pharmaceutical benefits that have the forms tenofovir disoproxil phosphate 291 mg tablet, tenofovir disoproxil maleate 300 mg tablet, and tenofovir disoproxil fumarate 300 mg tablet are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

6998

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

6982

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

6980

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must be nucleoside analogue naive, **AND**
- Patient must have detectable HBV DNA, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Note Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

Authority required (STREAMLINED)

6992

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must be nucleoside analogue naive, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR
- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by: (i) confirmed elevated serum ALT; or (ii) liver biopsy, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Note Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

Authority required (STREAMLINED)

6983

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have failed antihepadnaviral therapy, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Note Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

Authority required (STREAMLINED)

6984

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have failed antihepadnaviral therapy, **AND**
- Patient must have repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration, in conjunction with documented chronic hepatitis B infection; OR
- Patient must have repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months whilst on previous antihepadnaviral therapy, except in patients with evidence of poor compliance.

Note Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

tenofovir disoproxil fumarate 300 mg tablet, 30

10310P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*809.03	39.50	[a] Viread [GI]

tenofovir disoproxil maleate 300 mg tablet, 30

11155D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*809.03	39.50	[a] Tenofovir Disoproxil Mylan [AF]

tenofovir disoproxil phosphate 291 mg tablet, 30

11142K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*809.03	39.50	[a] Tenofovir GH [GQ]

▪ ZIDOVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

zidovudine 50 mg/5 mL oral liquid, 200 mL

10361H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	15	5	..	*672.40	39.50	Retrovir [VI]

zidovudine 100 mg capsule, 100

10266H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	5	..	*819.15	39.50	Retrovir [VI]

zidovudine 250 mg capsule, 40

10360G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	6	5	..	*1218.31	39.50	Retrovir [VI]

Non-nucleoside reverse transcriptase inhibitors

▪ EFAVIRENZ

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

efavirenz 200 mg tablet, 90

10336B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*543.79	39.50	Stocrin [MK]

efavirenz 30 mg/mL oral liquid, 180 mL

10275T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	7	5	..	*570.65	39.50	Stocrin [MK]

efavirenz 600 mg tablet, 30

10366N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*543.79	39.50	Stocrin [MK]

▪ ETRAVIRINE

Authority required (STREAMLINED)

5014

HIV infection

Clinical criteria:

- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must be antiretroviral experienced, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after each of at least 3 different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

etravirine 200 mg tablet, 60

10301E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1218.51	39.50	Intelence [JC]

▪ NEVIRAPINE

Authority required (STREAMLINED)

4526

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must have been stabilised on nevirapine immediate release, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

nevirapine 400 mg modified release tablet, 30

10303G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*334.01	39.50	[a] Nevirapine XR APOTEX [TX]	[a] Viramune XR [BY]

▪ NEVIRAPINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

nevirapine 10 mg/mL oral liquid, 240 mL

10319D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	5	..	*1397.15	39.50	Viramune [BY]

nevirapine 200 mg tablet, 60

10304H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*334.01	39.50	[a] Nevirapine Alphapharm [AF]	[a] Viramune [BY]

▪ RILPIVIRINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

rilpivirine 25 mg tablet, 30

10298B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*543.79	39.50	Edurant [JC]

Antivirals for treatment of HIV infections, combinations

▪ ABACAVIR + LAMIVUDINE

Note Pharmaceutical benefits that have the form tablet containing abacavir 600 mg (as sulfate) with lamivudine 300 mg and pharmaceutical benefits that have the form tablet containing abacavir 600 mg (as hydrochloride) with lamivudine 300 mg are equivalent for the purposes of substitution.

Authority required (STREAMLINED)

4527

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Population criteria:

- Patient must be aged 12 years or older, **AND**
- Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4528

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

Population criteria:

- Patient must be aged 12 years or older, **AND**
- Patient must weigh 40 kg or more.

abacavir 600 mg + lamivudine 300 mg tablet, 30

10357D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*611.49	39.50	[a] Kivexa [VI]

abacavir 600 mg + lamivudine 300 mg tablet, 30

11246X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*611.49	39.50	[a] Abacavir/Lamivudine GH 600/300 [GQ]

▪ ABACAVIR + LAMIVUDINE + ZIDOVUDINE

Authority required (STREAMLINED)

4495

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Population criteria:

- Patient must be aged 12 years or older, **AND**
- Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4480

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

- Patient must be aged 12 years or older, **AND**
- Patient must weigh 40 kg or more.

abacavir 300 mg + lamivudine 150 mg + zidovudine 300 mg tablet, 60

10305J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1038.23	39.50	Trizivir [VI]

▪ DARUNAVIR + COBICISTAT

Authority required (STREAMLINED)

6413

Human immunodeficiency virus (HIV) infection

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- The treatment must not be in combination with ritonavir.

Note The cobicistat component of the darunavir + cobicistat combination product provides the necessary pharmacokinetic enhancement of darunavir to achieve therapeutic levels of darunavir.

Authority required (STREAMLINED)

6428

Human immunodeficiency virus (HIV) infection

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- The treatment must not be in combination with ritonavir.

Note The cobicistat component of the darunavir + cobicistat combination product provides the necessary pharmacokinetic enhancement of darunavir to achieve therapeutic levels of darunavir.

Authority required (STREAMLINED)

6377

Human immunodeficiency virus (HIV) infection

Clinical criteria:

- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- The treatment must not be in combination with ritonavir, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after at least one antiretroviral regimen.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

Note The cobicistat component of the darunavir + cobicistat combination product provides the necessary pharmacokinetic enhancement of darunavir to achieve therapeutic levels of darunavir.

---

darunavir 800 mg + cobicistat 150 mg tablet, 30

10903W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1341.39	39.50	Prezcobix [JC]

▪ DOLUTEGRAVIR + ABACAVIR + LAMIVUDINE

Authority required (STREAMLINED)

4495

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Population criteria:

- Patient must be aged 12 years or older, **AND**

- Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4480

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

- Patient must be aged 12 years or older, **AND**
- Patient must weigh 40 kg or more.

dolutegravir 50 mg + abacavir 600 mg + lamivudine 300 mg tablet, 30

10345L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1847.83	39.50	Triumeq [VI]

▪ EMTRICITABINE + RILPIVIRINE + TENOFOVIR ALAFENAMIDE

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

emtricitabine 200 mg + rilpivirine 25 mg + tenofovir alafenamide 25 mg tablet, 30 tablets

11104K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*2016.85	39.50	Odefsey [GI]

▪ EMTRICITABINE + TENOFOVIR ALAFENAMIDE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

emtricitabine 200 mg + tenofovir alafenamide 10 mg tablet, 30

11099E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1500.85	39.50	Descovy [GI]

emtricitabine 200 mg + tenofovir alafenamide 25 mg tablet, 30

11113X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*1500.85	39.50	Descovy [GI]

▪ LAMIVUDINE + ZIDOVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

lamivudine 150 mg + zidovudine 300 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10284G	2	5	..	*580.57	39.50	[a] Combivir [VI]	[a] Lamivudine 150 mg + Zidovudine 300 mg Alphapharm [AF]

▪ LOPINAVIR + RITONAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

HSD (Community)

lopinavir 100 mg + ritonavir 25 mg tablet, 60

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10285H	2	5	..	*361.21	39.50	Kaletra [VE]

lopinavir 400 mg/5 mL + ritonavir 100 mg/5 mL oral liquid, 60 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10327M	10	5	..	*1329.55	39.50	Kaletra [VE]

lopinavir 200 mg + ritonavir 50 mg tablet, 120

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10272P	2	5	..	*1408.93	39.50	Kaletra [VE]

▪ TENOFOVIR + EMTRICITABINE

Note Pharmaceutical benefits that have the forms tenofovir disoproxil phosphate 291 mg with emtricitabine 200 mg tablet, tenofovir disoproxil maleate 300 mg with emtricitabine 200 mg tablet, and tenofovir disoproxil fumarate 300 mg with emtricitabine 200 mg tablet are equivalent for the purposes of substitution.

Authority required (STREAMLINED)
6985
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
6986
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg tablet, 30

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10347N	2	5	..	*1268.25	39.50	[a] Truvada [GI]

tenofovir disoproxil phosphate 291 mg + emtricitabine 200 mg tablet, 30

11146P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1268.25	39.50	[a] Tenofovir EMT GH [GQ]

tenofovir disoproxil maleate 300 mg + emtricitabine 200 mg tablet, 30

11149T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1268.25	39.50	[a] Tenofovir Disoproxil Emtricitabine Mylan 300/200 [AF]

▪ TENOFOVIR + EMTRICITABINE + EFAVIRENZ

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + efavirenz 600 mg tablet, 30

10297Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1784.25	39.50	Atripla [GI]

▪ TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30

10307L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1784.25	39.50	Stribild [GI]

▪ TENOFOVIR + EMTRICITABINE + RILPIVIRINE

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + rilpivirine 25 mg tablet, 30

10314W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1784.25	39.50	Eviplera [GI]

▪ TENOFOVIR ALAFENAMIDE + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT

Authority required (STREAMLINED)

4522

HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)
4470
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir alafenamide 10 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30

11114Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*2016.85	39.50	Genvoya [GI]

Other antivirals

▪ DOLUTEGRAVIR

Authority required (STREAMLINED)
4512
HIV infection
Treatment Phase: Initial
Clinical criteria:
- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)
4454
HIV infection
Treatment Phase: Continuing
Clinical criteria:
- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

dolutegravir 50 mg tablet, 30

10283F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1378.25	39.50	Tivicay [VI]

▪ ENFUVIRTIDE

Authority required (STREAMLINED)
5014
HIV infection
Clinical criteria:
- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must be antiretroviral experienced, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after each of at least 3 different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

enfuvirtide 90 mg injection [60 vials] (&) inert substance diluent [60 x 1.1 mL vials], 1 pack

10365M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*4251.85	39.50	Fuzeon [RO]

▪ MARAVIROC

Authority required (STREAMLINED)
5008
HIV infection
Clinical criteria:
- Patient must be infected with CCR5-tropic HIV-1, **AND**
- The treatment must be in addition to optimised background therapy, **AND**
- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must have experienced virological failure or clinical failure or genotypic resistance after each of at least 3 different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

A tropism assay to determine CCR5 only strain status must be performed prior to initiation. Individuals with CXCR4 tropism demonstrated at any time point are not eligible.

maraviroc 300 mg tablet, 60

10355B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1790.79	39.50	Celsentri [VI]

maraviroc 150 mg tablet, 60

10318C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1790.79	39.50	Celsentri [VI]

▪ RALTEGRAVIR

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

- Patient must be antiretroviral treatment naive, **AND**
- The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
- The treatment must be in combination with other antiretroviral agents.

raltegravir 600 mg tablet, 60

11248B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1311.69	39.50	Isentress HD [MK]

raltegravir 400 mg tablet, 60

10286J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1311.69	39.50	Isentress [MK]

▪ RALTEGRAVIR

Authority required (STREAMLINED)

4275

HIV infection

Treatment Phase: Initial

Clinical criteria:

- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**
- Patient must have a CD4 count of less than 500 per cubic millimetre; OR
- Patient must have symptomatic HIV disease.

Population criteria:

- Patient must be aged 2 years or older.

Authority required (STREAMLINED)

4274

HIV infection

Treatment Phase: Continuing

Clinical criteria:

- The treatment must be in combination with other antiretroviral agents, **AND**
- Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**
- Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

- Patient must be aged 2 years or older.

raltegravir 25 mg chewable tablet, 60

10299C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	6	5	..	*507.37	39.50	Isentress [MK]

raltegravir 100 mg chewable tablet, 60

10326L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	6	5	..	*1970.95	39.50	Isentress [MK]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Interferons

INTERFERON ALFA-2A

Authority required (STREAMLINED)

4993

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR
- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by confirmed elevated serum ALT or liver biopsy.

Authority required (STREAMLINED)

5036

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

HSD (Community)

interferon alfa-2a 3 million units/0.5 mL injection, 0.5 mL syringe

10317B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
30	5	..	*890.35	39.50	Roferon-A [RO]

interferon alfa-2a 9 million units/0.5 mL injection, 0.5 mL syringe

10369R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
30	5	..	*2594.35	39.50	Roferon-A [RO]

INTERFERON ALFA-2B

Authority required (STREAMLINED)

4993

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR
- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by confirmed elevated serum ALT or liver biopsy.

Authority required (STREAMLINED)

5036

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have detectable HBV DNA.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

interferon alfa-2b 30 million units/1.2 mL injection, 1.2 mL

10316Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	5	..	*595.81	39.50	Intron A Redipen [MK]

interferon alfa-2b 10 million units/mL injection, 5 x 1 mL vials

10370T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
3	5	..	*1462.18	39.50	Intron A [MK]

interferon alfa-2b 18 million units/3 mL injection, 3 mL vial

10340F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	15	5	..	*2594.20	39.50	Intron A [MK]

interferon alfa-2b 60 million units/1.2 mL injection, 1.2 mL

10292Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*1179.17	39.50	Intron A Redipen [MK]

interferon alfa-2b 25 million units/2.5 mL injection, 2.5 mL vial

10339E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	15	5	..	*3584.80	39.50	Intron A [MK]

interferon alfa-2b 18 million units/1.2 mL injection, 1.2 mL

10291P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*360.33	39.50	Intron A Redipen [MK]

▪ PEGINTERFERON ALFA-2A

Caution Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)

5010

Chronic hepatitis B infection

Clinical criteria:

- Patient must not have cirrhosis, **AND**
- Patient must not have previously received peginterferon alfa therapy for the treatment of hepatitis B, **AND**
- Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR
- Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**
- Patient must have evidence of chronic liver injury determined by confirmed elevated serum ALT or liver biopsy, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition.

Authority required (STREAMLINED)

5067

Chronic hepatitis B infection

Clinical criteria:

- Patient must have cirrhosis, **AND**
- Patient must have detectable HBV DNA, **AND**
- The treatment must be the sole PBS-subsidised therapy for this condition, **AND**
- The treatment must be limited to 1 course of treatment for a maximum duration of 48 weeks.

Patients with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

10278Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*2612.59	39.50	Pegasys [RO]

peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes

10280C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*2262.37	39.50	Pegasys [RO]

▪ NERVOUS SYSTEM

▪ PSYCHOLEPTICS

ANTIPSYCHOTICS

Diazepines, oxazepines, thiazepines and oxepines

▪ CLOZAPINE

Note Patients receiving clozapine under the PBS listing must be registered in the clozapine patient monitoring program relevant for the brand of clozapine being prescribed and dispensed: Novartis Clozaril Patient Monitoring System (eCPMS) or Hospira Clopineconnect.

Authority required (STREAMLINED)

4998

Schizophrenia

Treatment Phase: Continuing treatment

Treatment criteria:

- Must be treated by a psychiatrist; OR
- Must be treated by an authorised medical practitioner, with the agreement of the treating psychiatrist.

Clinical criteria:

- Patient must have previously received PBS-subsidised therapy with this drug for this condition, **AND**
- Patient must have completed at least 18 weeks therapy, **AND**
- Patient must be on a clozapine dosage considered stable by a treating psychiatrist, **AND**
- The treatment must be under the supervision and direction of a psychiatrist reviewing the patient at regular intervals.

A medical practitioner should request a quantity sufficient for up to one month's supply. Up to 5 repeats will be authorised.

clozapine 200 mg tablet, 100

10288L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*511.31	39.50	Clopine 200 [PF]

clozapine 25 mg tablet, 100

10289M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*75.79	39.50	[a] Clopine 25 [PF]	[a] Clozaril 25 [GO]

clozapine 100 mg tablet, 100

10358E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*259.23	39.50	[a] Clopine 100 [PF]	[a] Clozaril 100 [GO]

clozapine 50 mg/mL oral liquid, 100 mL

10341G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	147.55	39.50	Clopine Suspension [PF]

clozapine 50 mg tablet, 100

10302F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*141.61	39.50	Clopine 50 [PF]

Botulinum Toxin Program

MUSCULO-SKELETAL SYSTEM 1254

MUSCLE RELAXANTS 1254

MUSCLE RELAXANTS, PERIPHERALLY ACTING AGENTS 1254

MUSCULO-SKELETAL SYSTEM

MUSCLE RELAXANTS

MUSCLE RELAXANTS, PERIPHERALLY ACTING AGENTS

Other muscle relaxants, peripherally acting agents

BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5221

Blepharospasm or hemifacial spasm

Clinical criteria:

- Patient must have blepharospasm; OR
- Patient must have hemifacial spasm.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an ophthalmologist; OR
- Must be treated by an otolaryngology head and neck surgeon; OR
- Must be treated by a plastic surgeon.

Population criteria:

- Patient must be aged 12 years or older.

botulinum toxin type A 100 units injection, 1 vial

10997T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4	..	..	*1626.07	39.50	Botox [AG]

BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5406

Spasmodic torticollis

Clinical criteria:

- Patient must have spasmodic torticollis, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be as adjunctive therapy to current standard care.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a rehabilitation specialist.

botulinum toxin type A 100 units injection, 1 vial

11023E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4	..	..	*1626.07	39.50	Botox [AG]

BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5409

Urinary incontinence

Clinical criteria:

- The condition must be due to neurogenic detrusor overactivity, as demonstrated by urodynamic study, **AND**
- The condition must be inadequately controlled by anti-cholinergic therapy, **AND**
- Patient must experience at least 14 episodes of urinary incontinence per week prior to commencement of treatment with Botulinum Toxin Type A Neurotoxin Complex, **AND**
- Patient must be willing and able to self-catheterise, **AND**
- The treatment must not continue if the patient does not achieve a 50% or greater reduction from baseline in urinary incontinence episodes 6-12 weeks after the first treatment, **AND**
- Patient must have multiple sclerosis; OR
- Patient must have a spinal cord injury; OR
- Patient must be aged 18 years or older and have spina bifida.

Treatment criteria:

- Must be treated by a urologist; OR
- Must be treated by a urogynaecologist.

botulinum toxin type A 100 units injection, 1 vial

10993N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1626.07	39.50	Botox [AG]

▪ BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5359

Dynamic equinus foot deformity

Clinical criteria:

- The condition must be due to spasticity, **AND**
- Patient must have cerebral palsy, **AND**
- Patient must be ambulant.

Population criteria:

- Patient must be aged from 2 to 17 years inclusive.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR
- Must be treated by a rehabilitation specialist.

Authority required (STREAMLINED)

5407

Dynamic equinus foot deformity

Clinical criteria:

- The condition must be due to spasticity, **AND**
- Patient must have cerebral palsy, **AND**
- Patient must be ambulant, **AND**
- Patient must have commenced PBS-subsidised treatment with Botulinum Toxin Type A Purified Neurotoxin Complex as a paediatric patient.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR
- Must be treated by a rehabilitation specialist.

botulinum toxin type A 100 units injection, 1 vial

10998W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1626.07	39.50	Botox [AG]

▪ BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5262

Chronic migraine

Treatment criteria:

- Must be treated by a neurologist.

Clinical criteria:

- Patient must have experienced an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, prior to commencement of treatment with botulinum toxin type A neurotoxin, **AND**
- Patient must have experienced an inadequate response, intolerance or a contraindication to at least three prophylactic migraine medications prior to commencement of treatment with botulinum toxin type A neurotoxin, **AND**
- Patient must have achieved and maintained a 50% or greater reduction from baseline in the number of headache days per month after two treatment cycles (each of 12 weeks duration) in order to be eligible for continuing PBS-subsidised treatment, **AND**
- Patient must be appropriately managed by his or her practitioner for medication overuse headache, prior to initiation of treatment with botulinum toxin.

Population criteria:

- Patient must be aged 18 years or older.

Prophylactic migraine medications are propanolol, amitriptylin, methsergide, pizotifen, cyproheptadine or topiramate.

botulinum toxin type A 100 units injection, 1 vial

11000Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1626.07	39.50	Botox [AG]

▪ BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

6953

Urinary incontinence

Treatment criteria:

- Must be treated by a urologist; OR
- Must be treated by a gynaecologist.

Clinical criteria:

- The condition must be due to idiopathic overactive bladder, **AND**
- The condition must have been inadequately controlled by therapy involving at least two alternative anti-cholinergic agents, **AND**
- Patient must experience at least 14 episodes of urinary incontinence per week prior to commencement of treatment with botulinum toxin type A neurotoxin complex, **AND**
- Patient must be willing and able to self-catheterise, **AND**
- The treatment must not continue if the patient does not achieve a 50% or greater reduction from baseline in urinary incontinence episodes 6-12 weeks after the first treatment.

Population criteria:

- Patient must be aged 18 years or older.

botulinum toxin type A 100 units injection, 1 vial

11004E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1626.07	39.50	Botox [AG]

▪ BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5408

Severe primary axillary hyperhidrosis

Clinical criteria:

- Patient must have previously failed topical aluminium chloride hexahydrate after one to two months of treatment; OR
- Patient must be intolerant to topical aluminium chloride hexahydrate treatment.

Population criteria:

- Patient must be aged 12 years or older.

Treatment criteria:

- Must be treated by a dermatologist; OR
- Must be treated by a neurologist; OR
- Must be treated by a paediatrician.

Maximum number of treatments per year is 3, with no less than 4 months to elapse between treatments.

botulinum toxin type A 100 units injection, 1 vial

11016T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1626.07	39.50	Botox [AG]

▪ BOTULINUM TOXIN TYPE A

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5178

Moderate to severe spasticity of the upper limb

Clinical criteria:

- Patient must have cerebral palsy.

Population criteria:

- Patient must be aged from 2 to 17 years inclusive.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR

- Must be treated by a rehabilitation specialist; OR
- Must be treated by a plastic surgeon.

Authority required (STREAMLINED)

5261

Moderate to severe spasticity of the upper limb

Clinical criteria:

- Patient must have cerebral palsy, **AND**
- Patient must have commenced PBS-subsidised treatment with Botulinum Type A Neurotoxin Complex as a paediatric patient.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR
- Must be treated by a rehabilitation specialist; OR
- Must be treated by a plastic surgeon.

Note Contact the Department of Human Services before commencing PBS-subsidised treatment in cerebral palsy patients who have been treated for moderate to severe spasticity of the upper limb with non-PBS-subsidised botulinum toxin prior to the age of 18.

Authority required (STREAMLINED)

5220

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

- The condition must be moderate to severe spasticity of the upper limb/s following stroke, defined as a Modified Ashworth Scale rating of 3 or more, **AND**
- The treatment must not be initiated until three months post-stroke, **AND**
- The treatment must only be used as second line therapy when standard management has failed; OR
- The treatment must only be used as an adjunct to physical therapy, **AND**
- The treatment must not continue if the patient does not respond (defined as not having had a decrease in spasticity rating greater than 1, using the Modified Ashworth Scale, in at least one joint) after two treatment periods (total Botox, Dysport, and Xeomin), **AND**
- The treatment must not exceed 4 treatment periods (total Botox, Dysport, and Xeomin) per upper limb per lifetime, **AND**
- Patient must not have established severe contracture in the limb to be treated.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a rehabilitation specialist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a geriatrician.

The date of the stroke must be documented in the patient's medical records when treatment is initiated.

Standard management includes physiotherapy and/or oral spasticity agents.

botulinum toxin type A 100 units injection, 1 vial

10999X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4	..	..	*1626.07	39.50	Botox [AG]

▪ CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5220

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

- The condition must be moderate to severe spasticity of the upper limb/s following stroke, defined as a Modified Ashworth Scale rating of 3 or more, **AND**
- The treatment must not be initiated until three months post-stroke, **AND**
- The treatment must only be used as second line therapy when standard management has failed; OR
- The treatment must only be used as an adjunct to physical therapy, **AND**
- The treatment must not continue if the patient does not respond (defined as not having had a decrease in spasticity rating greater than 1, using the Modified Ashworth Scale, in at least one joint) after two treatment periods (total Botox, Dysport, and Xeomin), **AND**
- The treatment must not exceed 4 treatment periods (total Botox, Dysport, and Xeomin) per upper limb per lifetime, **AND**
- Patient must not have established severe contracture in the limb to be treated.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a rehabilitation specialist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a geriatrician.

The date of the stroke must be documented in the patient's medical records when treatment is initiated.
Standard management includes physiotherapy and/or oral spasticity agents.

clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 vial

10988H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*1272.29	39.50	Dysport [IS]

clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 vial

10982B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1420.91	39.50	Dysport [IS]

▪ CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5405

Blepharospasm or hemifacial spasm

Clinical criteria:

- Patient must have blepharospasm; OR
- Patient must have hemifacial spasm.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an ophthalmologist; OR
- Must be treated by an otolaryngology head and neck surgeon; OR
- Must be treated by a plastic surgeon.

clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 vial

11022D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*1272.29	39.50	Dysport [IS]

clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 vial

10987G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1420.91	39.50	Dysport [IS]

▪ CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5406

Spasmodic torticollis

Clinical criteria:

- Patient must have spasmodic torticollis, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be as adjunctive therapy to current standard care.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a rehabilitation specialist.

clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 vial

11015R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*1272.29	39.50	Dysport [IS]

clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 vial

11007H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	..	..	*1420.91	39.50	Dysport [IS]

▪ CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5359

Dynamic equinus foot deformity

Clinical criteria:

- The condition must be due to spasticity, **AND**
- Patient must have cerebral palsy, **AND**
- Patient must be ambulant.

Population criteria:

- Patient must be aged from 2 to 17 years inclusive.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR
- Must be treated by a rehabilitation specialist.

Authority required (STREAMLINED)

5332

Dynamic equinus foot deformity

Clinical criteria:

- The condition must be due to spasticity, **AND**
- Patient must be an ambulant cerebral palsy patient, **AND**
- Patient must have commenced on PBS-subsidised treatment with clostridium botulinum type A toxin-haemagglutinin complex as a paediatric patient.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a paediatrician; OR
- Must be treated by a rehabilitation specialist.

clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11006G	2	..	..	*1272.29	39.50	Dysport [IS]

clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10981Y	4	..	..	*1420.91	39.50	Dysport [IS]

▪ INCOBOTULINUMTOXINA

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5220

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

- The condition must be moderate to severe spasticity of the upper limb/s following stroke, defined as a Modified Ashworth Scale rating of 3 or more, **AND**
- The treatment must not be initiated until three months post-stroke, **AND**
- The treatment must only be used as second line therapy when standard management has failed; OR
- The treatment must only be used as an adjunct to physical therapy, **AND**
- The treatment must not continue if the patient does not respond (defined as not having had a decrease in spasticity rating greater than 1, using the Modified Ashworth Scale, in at least one joint) after two treatment periods (total Botox, Dysport, and Xeomin), **AND**
- The treatment must not exceed 4 treatment periods (total Botox, Dysport, and Xeomin) per upper limb per lifetime, **AND**
- Patient must not have established severe contracture in the limb to be treated.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an orthopaedic surgeon; OR
- Must be treated by a rehabilitation specialist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a geriatrician.

The date of the stroke must be documented in the patient's medical records when treatment is initiated.
Standard management includes physiotherapy and/or oral spasticity agents.

incobotulinumtoxinA 100 mouse LD50 units injection, 1 x 100 mouse LD50 units vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10983C	4	..	..	*1547.15	39.50	Xeomin [EZ]

▪ INCOBOTULINUMTOXINA

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5360

Blepharospasm

Clinical criteria:

- Patient must have blepharospasm.

Population criteria:

- Patient must be aged 18 years or older.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by an ophthalmologist; OR
- Must be treated by an otolaryngology head and neck surgeon; OR
- Must be treated by a plastic surgeon.

incobotulinumtoxinA 100 mouse LD50 units injection, 1 x 100 mouse LD50 units vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10994P	4	..	..	*1547.15	39.50	Xeomin [EZ]

▪ INCOBOTULINUMTOXINA

Caution Contraindications to treatment include known sensitivity to botulinum toxin.

Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

Authority required (STREAMLINED)

5222

Spasmodic torticollis

Clinical criteria:

- Patient must have spasmodic torticollis, **AND**
- The treatment must be as monotherapy; OR
- The treatment must be as adjunctive therapy to current standard care.

Treatment criteria:

- Must be treated by a neurologist; OR
- Must be treated by a plastic surgeon; OR
- Must be treated by a rehabilitation specialist.

Population criteria:

- Patient must be aged 18 years or older.

incobotulinumtoxinA 100 mouse LD50 units injection, 1 x 100 mouse LD50 units vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11005F	4	..	..	*1547.15	39.50	Xeomin [EZ]

Growth Hormone Program

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....1262

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES 1262
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES 1262

▪ SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

▪ PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

Somatropin and somatropin agonists

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR
- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR

- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 25th percentile for age and sex, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10518N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Omnitrope Surepal 5 [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10514J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope Surepal 10 [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

6311E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope [SZ]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10446T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Omnitrope Surepal 15 [SZ]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR
- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

5. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven

biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven

biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**

- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 12 units (4 mg) injection [1 vial] (&) inert substance diluent [1 vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
6266T	1	1	..	180.12	39.50	Zomacton [FP]

somatropin 30 units (10 mg) injection [1 vial] (&) inert substance diluent [1 mL syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
6310D	1	1	..	439.58	39.50	Zomacton [FP]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR

- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**

- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

5. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR

- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 25th percentile for age and sex, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR

- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 60 units (20 mg/2.5 mL) injection, 2.5 mL cartridge

3388H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	872.01	39.50	Saizen [SG]

somatropin 36 units (12 mg/1.5 mL) injection, 1.5 mL cartridge

5824M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	526.07	39.50	Saizen [SG]

somatropin 18 units (6 mg/1.03 mL) injection, 1.03 mL cartridge

5822K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	266.61	39.50	Saizen [SG]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR

- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR
- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**

- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**

- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND
5. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND
6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR

- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height at or below the 25th percentile for age and sex, **AND**

- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

5818F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin FlexPro [NO]

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

6295H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

5819G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin FlexPro [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

6296J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin SimpleXx [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

5820H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin FlexPro [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

6297K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/2 mL) injection, 2 mL cartridge

9604L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	NutropinAq [IS]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR
- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

5. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine,

clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine,

clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**

- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 25th percentile for age and sex, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be prepubertal.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND
3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR
(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND
4. A bone age result performed within the last 12 months; AND
5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND
6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND
7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 72 units (24 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

6345Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1044.99	39.50	Humatrope [LY]

somatropin 18 units (6 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

6169Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	266.61	39.50	Humatrope [LY]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

6170R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Humatrope [LY]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

GH

Authority required

Short stature and slow growth

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 160.1 cm; OR
- Patient must be female and must not have maturational or constitutional delay in combination with an estimated mature height equal to or above 148.0 cm.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation of the patient's maturational or constitutional delay status; AND

6. If the patient has maturational or constitutional delay, confirmation that the patient has an estimated mature height below the 1st adult height percentile; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

5. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Confirmation that the patient has precocious puberty; AND

7. Confirmation that the patient is undergoing Gonadotropin Releasing Hormone agonist therapy, for pubertal suppression; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity above the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity above the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of greater than 8 cm per year, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

7. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

8. Confirmation that the patient has hypothalamic obesity; AND

9. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Testing for biochemical growth hormone deficiency must have been performed at a time when all other pituitary hormone deficits were being adequately replaced.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height at or below the 95th percentile for age on the Turner syndrome growth curve for girls, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Initial treatment

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

Clinical criteria:

- Patient must have a current height below the 1st percentile for age and sex, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR

- Patient must be male, have a bone age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity below the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity below the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

6. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a current height at or below the 25th percentile for age and sex, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must be male, have a chronological age of at least 12 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be male, have a bone age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a chronological age of at least 10 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must be female, have a bone age of at least 8 years and a growth velocity equal to or less than the 25th percentile for bone age and sex measured over a 6 month interval; OR
- Patient must have a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both 12 and 6 month intervals; OR
- Patient must have a bone age of 2.5 years or less and an annual growth velocity of 8 cm per year or less, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. (a) A minimum of 12 months of recent growth data (height and weight) at intervals no greater than six months. The most recent data must not be older than three months; OR

(b) A minimum of 6 months of recent growth data (height and weight) for older children (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over). The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature and poor body composition due to Prader-Willi syndrome

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have diagnostic results consistent with Prader-Willi syndrome (the condition must be genetically proven); OR
- Patient must have a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist, **AND**
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with no sleep disorders identified; OR
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with sleep disorders identified which are not of sufficient severity to require treatment; OR
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with sleep disorders identified for which the patient is currently receiving ameliorative treatment, **AND**
- Patient must not have uncontrolled morbid obesity, defined as a body weight greater than 200% of ideal body weight for height and sex, with ideal body weight derived by calculating the 50th percentile weight for the patient's current height, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have previously received treatment under the PBS S100 Growth Hormone Program, **AND**
- Patient must not have a chronological age of 18 years or greater.

Treatment criteria:

- Must be treated by a specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a specialist or consultant physician in general paediatrics in consultation with a nominated specialist or consultant physician in paediatric endocrinology.

The maximum duration of the initial treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for initial treatment; AND

3. A minimum of 6 months of recent growth data (height, weight and waist circumference). The most recent data must not be older than three months; AND

4. The date that skeletal maturity was achieved (if applicable); AND

5. (a) Confirmation that the patient has diagnostic results consistent with Prader-Willi syndrome; OR

(b) Confirmation that the patient has a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist

6. Confirmation that the patient has been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months and any sleep disorders identified via polysomnography that required treatment have been addressed; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with 1 repeat allowed)

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

SOMATROPIN (Recombinant human growth hormone) Powder for injection 5 mg (15 i.u.) with diluent in pre-filled pen (with preservative), 1

9585L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Genotropin GoQuick [PF]

SOMATROPIN (Recombinant human growth hormone) Powder for injection 12 mg (36 i.u.) with diluent in pre-filled pen (with preservative), 1

9586M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin GoQuick [PF]

somatropin 4.8 units (1.6 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6317L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	491.48	39.50	Genotropin MiniQuick [PF]

somatropin 4.2 units (1.4 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6316K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	430.93	39.50	Genotropin MiniQuick [PF]

somatropin 6 units (2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6319N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	612.55	39.50	Genotropin MiniQuick [PF]

somatropin 5.4 units (1.8 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6318M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	552.02	39.50	Genotropin MiniQuick [PF]

somatropin 3 units (1 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6314H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	309.85	39.50	Genotropin MiniQuick [PF]

somatropin 3.6 units (1.2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6315J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	370.39	39.50	Genotropin MiniQuick [PF]

somatropin 2.4 units (800 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6313G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	249.31	39.50	Genotropin MiniQuick [PF]

somatropin 1.8 units (600 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

9628R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	188.78	39.50	Genotropin MiniQuick [PF]

somatropin 400 microgram injection, syringe [7] (&) inert substance diluent, syringe [7 x 0.25 mL syringes], 1 pack

10902T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	128.23	39.50	Genotropin MiniQuick [PF]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [1 mL cartridge], 1 pack

6312F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin [PF]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine,

clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special**

Arrangement 2015 and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**

- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 12 units (4 mg) injection [1 vial] (&) inert substance diluent [1 vial], 1 pack

10452D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	180.12	39.50	Zomacton [FP]

somatropin 30 units (10 mg) injection [1 vial] (&) inert substance diluent [1 mL syringe], 1 pack

10440L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Zomacton [FP]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR

- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

somatropin 12 units (4 mg) injection [1 vial] (&) inert substance diluent [1 vial], 1 pack

10447W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	180.12	39.50	Zomacton [FP]

somatropin 30 units (10 mg) injection [1 vial] (&) inert substance diluent [1 mL syringe], 1 pack

10455G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Zomacton [FP]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation
Treatment Phase: Continuing treatment as a reclassified patient
Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR

- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a paediatric endocrinologist; OR
- Must be treated by a medical practitioner in consultation with an endocrinologist specialising in paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30ml/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10507B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Omnitrope Surepal 5 [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10441M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10506Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope Surepal 10 [SZ]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10490D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Omnitrope Surepal 15 [SZ]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine,

clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR

- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30ml/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10432C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin FlexPro [NO]

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10469B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10439K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10451C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin FlexPro [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10449Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin FlexPro [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10468Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/2 mL) injection, 2 mL cartridge

10478L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	NutropinAq [IS]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**

- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR

- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR

- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**

- Patient must not have an active tumour or evidence of tumour growth or activity.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND
3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30ml/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 60 units (20 mg/2.5 mL) injection, 2.5 mL cartridge

10497L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	872.01	39.50	Saizen [SG]

somatropin 36 units (12 mg/1.5 mL) injection, 1.5 mL cartridge

10483R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	526.07	39.50	Saizen [SG]

somatropin 18 units (6 mg/1.03 mL) injection, 1.03 mL cartridge

10462P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	266.61	39.50	Saizen [SG]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special**

Arrangement 2015 and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be prepubertal.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic

dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR

- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be prepubertal.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30ml/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 72 units (24 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10476J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1044.99	39.50	Humatrope [LY]

somatropin 18 units (6 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10482Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	266.61	39.50	Humatrope [LY]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10487Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Humatrope [LY]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

If a patient receiving treatment under the indication 'short stature associated with chronic renal insufficiency' undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program)**

Special Arrangement 2015 and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature asscіated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10512G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Omnitrope Surepal 5 [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10481P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope [SZ]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10519P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Omnitrope Surepal 10 [SZ]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10485W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Omnitrope Surepal 15 [SZ]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**

- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be prepubertal.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND
6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND
7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

If a patient receiving treatment under the indication 'short stature associated with chronic renal insufficiency' undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR

- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR

- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be prepubertal.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 72 units (24 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10502R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	1044.99	39.50	Humatrope [LY]

somatropin 18 units (6 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10429X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	266.61	39.50	Humatrope [LY]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [3.15 mL syringe], 1 pack

10461N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Humatrope [LY]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

GH

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**

- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND
6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND
7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

If a patient receiving treatment under the indication 'short stature associated with chronic renal insufficiency' undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR

- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR

- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6

months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10437H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin SimpleXx [NO]

somatropin 15 units (5 mg/1.5 mL) injection, 1.5 mL cartridge

10467X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Norditropin FlexPro [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10448X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin SimpleXx [NO]

somatropin 30 units (10 mg/1.5 mL) injection, 1.5 mL cartridge

10496K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	Norditropin FlexPro [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10470C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin SimpleXx [NO]

somatropin 45 units (15 mg/1.5 mL) injection, 1.5 mL cartridge

10489C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	655.80	39.50	Norditropin FlexPro [NO]

somatropin 30 units (10 mg/2 mL) injection, 2 mL cartridge

10438J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	439.58	39.50	NutropinAq [IS]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**

- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**

- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic

dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**

- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6

months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Population criteria:

- Patient must be aged 3 years or older.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

If a patient receiving treatment under the indication 'short stature associated with chronic renal insufficiency' undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Population criteria:

- Patient must be aged 3 years or older.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

somatropin 60 units (20 mg/2.5 mL) injection, 2.5 mL cartridge

10442N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	872.01	39.50	Saizen [SG]

somatropin 36 units (12 mg/1.5 mL) injection, 1.5 mL cartridge

10495J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	526.07	39.50	Saizen [SG]

somatropin 18 units (6 mg/1.03 mL) injection, 1.03 mL cartridge

10458K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	266.61	39.50	Saizen [SG]

▪ SOMATROPIN

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height and weight, not older than three months); AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND
2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND
3. Recent growth data (height and weight, not older than three months); AND
4. A bone age result performed within the last 12 months; AND
5. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND
6. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND
7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

If a patient receiving treatment under the indication 'short stature associated with chronic renal insufficiency' undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and poor body composition due to Prader-Willi syndrome

Treatment Phase: Recommencement of treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and poor body composition due to Prader Willi syndrome category, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a current bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for the initial treatment period or 26 weeks for subsequent treatment periods, whichever applies); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for the initial treatment period or 26 weeks for subsequent treatment periods, whichever applies), unless response was affected by a significant medical illness; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for the initial treatment period or 26 weeks for subsequent treatment periods, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for the initial treatment period or 26 weeks for subsequent treatment periods, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for the initial treatment period or 26 weeks for subsequent treatment periods, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have been re-evaluated via polysomnography for airway obstruction and apnoea during the initial 32 week treatment period and any sleep disorders identified that required treatment must have been addressed, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Population criteria:

- Patient must not have a chronological age of equal to or greater than 18 years.

Clinical criteria:

- Patient must not have developed uncontrolled morbid obesity, defined as a body weight greater than 200% of ideal body weight for height and sex, with ideal body weight derived by calculating the 50th percentile weight for the patient's current height.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment; AND

3. Recent growth data (height, weight, and waist circumference, not older than three months); AND

4. The date at which skeletal maturity was achieved (if applicable) [Note: A bone age reading should be performed at least once every 12 months prior to attainment of skeletal maturity.]; AND

5. Confirmation that during the initial 32 week treatment period, the patient was re-evaluated via polysomnography for airway obstruction and apnoea, and any sleep disorders that were identified have been addressed; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If recommencement of treatment is sought under a different indication than that under which the patient was previously receiving treatment an application for **recommencement of treatment as a reclassified patient** should be submitted**.**

Authority required

Short stature and slow growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of

growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic

dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Recent growth data (height and weight, not older than three months); AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must not have a bone age of 13.5 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Recent growth data (height and weight, not older than three months); AND

6. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Recommencement of treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Recent growth data (height and weight, not older than three months); AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Authority required

Short stature and poor body composition due to Prader-Willi syndrome

Treatment Phase: Recommencement of treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and poor body composition due to Prader-Willi syndrome, **AND**
- Patient must have had a lapse in growth hormone treatment, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a current bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies) , unless response was affected by an adverse reaction to growth hormone; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems,

AND

- Patient must have diagnostic results consistent with Prader-Willi syndrome (the condition must be genetically proven); OR
- Patient must have a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist, **AND**
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea whilst on growth hormone treatment and any sleep disorders identified that required treatment must have been addressed; OR
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with no sleep disorders identified; OR
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with sleep disorders identified which are not of sufficient severity to require treatment; OR
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea within the last 12 months with sleep disorders identified for which the patient is currently receiving ameliorative treatment, **AND**
- Patient must not have uncontrolled morbid obesity, defined as a body weight greater than 200% of ideal body weight for height and sex, with ideal body weight derived by calculating the 50th percentile weight for the patient's current height,

AND

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 18 years or greater.

The maximum duration of each recommencement treatment phase is 32 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for recommencement of treatment as a reclassified patient; AND

3. (a) Confirmation that the patient has diagnostic results consistent with Prader-Willi syndrome, OR

(b) Confirmation that the patient has a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist; AND

4. Confirmation that the patient has been evaluated via polysomnography for airway obstruction and apnoea whilst on growth hormone treatment, and any sleep disorders identified via the polysomnography that required treatment have been addressed; AND

5. Recent growth data (height and weight, not older than three months); AND

6. The date that skeletal maturity was achieved (if applicable); AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 16 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

SOMATROPIN (Recombinant human growth hormone) Powder for injection 5 mg (15 i.u.) with diluent in pre-filled pen (with preservative), 1

10435F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Genotropin GoQuick [PF]

SOMATROPIN (Recombinant human growth hormone) Powder for injection 12 mg (36 i.u.) with diluent in pre-filled pen (with preservative), 1

10426R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin GoQuick [PF]

somatropin 4.8 units (1.6 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10498M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	491.48	39.50	Genotropin MiniQuick [PF]

somatropin 4.2 units (1.4 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10434E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	430.93	39.50	Genotropin MiniQuick [PF]

somatropin 6 units (2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10472E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	612.55	39.50	Genotropin MiniQuick [PF]

somatropin 5.4 units (1.8 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10501Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	552.02	39.50	Genotropin MiniQuick [PF]

somatropin 3 units (1 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10430Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	309.85	39.50	Genotropin MiniQuick [PF]

somatropin 3.6 units (1.2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10457J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	370.39	39.50	Genotropin MiniQuick [PF]

somatropin 2.4 units (800 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10463Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	249.31	39.50	Genotropin MiniQuick [PF]

somatropin 1.8 units (600 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10477K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	188.78	39.50	Genotropin MiniQuick [PF]

somatropin 400 microgram injection, syringe [7] (&) inert substance diluent, syringe [7 x 0.25 mL syringes], 1 pack

10908D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	128.23	39.50	Genotropin MiniQuick [PF]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [1 mL cartridge], 1 pack

10444Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin [PF]

▪ SOMATROPIN

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and slow growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

GH

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with biochemical growth hormone deficiency category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the growth retardation secondary to an intracranial lesion, or cranial irradiation category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available

on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 5 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

When a patient receiving treatment under the indication risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants reaches or surpasses 5 years of age (chronological), prescribers should seek reclassification to the indication 'short stature due to biochemical growth hormone deficiency'.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the biochemical growth hormone deficiency and precocious puberty category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR

- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

GH

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth category, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with Turner syndrome category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an annualised growth velocity for bone age at or above the mean growth velocity for untreated Turner Syndrome girls (using the Turner Syndrome - Ranke growth velocity chart) while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature due to short stature homeobox (SHOX) gene disorders category, **AND**
- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature associated with chronic renal insufficiency category, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**

- Patient must not have been on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved the 50th percentile growth velocity for bone age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved an increase in height standard deviation score for chronological age and sex while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved a minimum growth velocity of 4cm/year while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have achieved and maintained mid parental height standard deviation score while on the maximum dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have undergone a renal transplant within the 12 month period immediately prior to the date of application, **AND**
- Patient must not have an eGFR equal to or greater than 30mL/min/1.73m^2, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7 cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0 cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. A bone age result performed within the last 12 months; AND

5. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and poor body composition due to Prader-Willi syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under the short stature and poor body composition due to Prader-Willi syndrome category, **AND**
- Patient must have been re-evaluated via polysomnography for airway obstruction and apnoea during the initial 32 week treatment period and any sleep disorders identified that required treatment must have been addressed, **AND**
- Patient must not have been on the maximum dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved height percentile for age and sex while on the maximum dose of 7.5mg/m2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved body mass index SDS for age and sex while on the maximum dose of 7.5mg/m2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR

- Patient must have maintained or improved waist circumference while on the maximum dose of 7.5mg/m2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved waist/height ratio (waist circumference in centimetres divided by height in centimetres) while on the maximum dose of 7.5mg/m2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have achieved an increase in height percentile with reference to the untreated Prader-Willi syndrome standards for age and sex while on the maximum dose of 7.5mg/m2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must not have been on the maximum dose of 0.04mg/kg/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved body mass index while on the maximum dose of 0.04mg/kg/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved body mass index SDS for age and sex while on the maximum dose of 0.04mg/kg/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved waist circumference while on the maximum dose of 0.04mg/kg/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved waist/height ratio (waist circumference in centimetres divided by height in centimetres) while on the maximum dose of 0.04mg/kg/week for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have maintained or improved weight SDS for age and sex while on the maximum dose of 0.04mg/kg/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), and have a bone age at or above skeletal maturity (15.5 for males and 13.5 for females), **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Population criteria:

- Patient must not have a chronological age of equal to or greater than 18 years.

Clinical criteria:

- Patient must not have developed uncontrolled morbid obesity, defined as a body weight greater than 200% of ideal body weight for height and sex, with ideal body weight derived by calculating the 50th percentile weight for the patient's current height.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment; AND

3. Growth data (height, weight and waist circumference) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

4. The date at which skeletal maturity was achieved (if applicable) [Note: A bone age reading should be performed at least once every 12 months prior to attainment of skeletal maturity.]; AND

5. Confirmation that during the initial 32 week treatment period, the patient was re-evaluated via polysomnography for airway obstruction and apnoea, and any sleep disorders that were identified have been addressed; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Maintenance is defined as a value within a 5% tolerance (this allows for seasonal and other measurement variations).

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and slow growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and slow growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication short stature associated with chronic renal insufficiency, have undergone a renal transplant and a 12 month period of observation following the transplant, and have an estimated glomerular filtration rate of greater than or equal to 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula; OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months;

OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment; AND

4. A bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature associated with biochemical growth hormone deficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with biochemical growth hormone deficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and have reached or surpassed 5 years of age (chronological); OR
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR

- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(c) Confirmation that the patient has previously received treatment under the indication **risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants** and has reached or surpassed 5 years of age (chronological); AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Biochemical growth hormone deficiency should not be secondary to an intracranial lesion or cranial irradiation for applications under this category.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs

Reply Paid 9826
HOBART TAS 7001

Authority required

Growth retardation secondary to an intracranial lesion, or cranial irradiation

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than growth retardation secondary to an intracranial lesion, or cranial irradiation, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had an intracranial lesion and have undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR
- Patient must have had an intracranial lesion, have received medical advice that it is unsafe to treat the intracranial lesion, and have undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR
- Patient must have received cranial irradiation without having had an intracranial lesion, and have undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8cm per year or less in the 12 month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**

- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has had an intracranial lesion and has undergone a 12 month period of observation following completion of treatment for the intracranial lesion (all treatment); OR

(b) Confirmation that the patient has had an intracranial lesion, has received medical advice that it is unsafe to treat the intracranial lesion, and has undergone a 12 month period of observation since initial diagnosis of the intracranial lesion; OR

(c) Confirmation that the patient has received cranial irradiation without having had an intracranial lesion, and has undergone a 12 month period of observation following completion of treatment for the condition for which cranial irradiation was received; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than risk of hypoglycaemia secondary to growth hormone deficiency in neonates/infants, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a chronological age of less than 2 years, **AND**
- Patient must have a documented clinical risk of hypoglycaemia, **AND**
- Patient must have documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has a documented clinical risk of hypoglycaemia; AND

4. Confirmation that the patient has documented evidence that the risk of hypoglycaemia is secondary to biochemical growth hormone deficiency; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Biochemical growth hormone deficiency and precocious puberty

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than biochemical growth hormone deficiency and precocious puberty, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**

- Patient must be male and have commenced puberty (demonstrated by Tanner stage 2 genital or pubic hair development or testicular volumes greater than or equal to 4 mL) before the chronological age of 9 years; OR
- Patient must be female and have commenced puberty (demonstrated by Tanner stage 2 breast or pubic hair development) before the chronological age of 8 years; OR
- Patient must be female and menarche occurred before the chronological age of 10 years, **AND**
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must be undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. Confirmation that the patient has precocious puberty; AND

4. Confirmation that the patient is undergoing Gonadotrophin Releasing Hormone agonist therapy for pubertal suppression; AND

5. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than hypothalamic-pituitary disease secondary to a structural lesion, with hypothalamic obesity driven growth, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a structural lesion that is not neoplastic; OR
- Patient must have had a structural lesion that was neoplastic and have undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR
- Patient must have a structural lesion that is neoplastic, have received medical advice that it is unsafe to treat the structural lesion, and have undergone a 12 month period of observation since initial diagnosis of the structural lesion,

AND

- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 2 pharmacological growth hormone stimulation tests (e.g. arginine, clonidine, glucagon, insulin); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 pharmacological growth hormone stimulation test (e.g. arginine, clonidine, glucagon, insulin) and 1 physiological growth hormone stimulation test (e.g. sleep, exercise); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) with other evidence of growth hormone deficiency, including septo-optic dysplasia (absent corpus callosum and/or septum pellucidum), midline abnormality including optic nerve hypoplasia, cleft lip and palate, midfacial hypoplasia and central incisor, ectopic and/or absent posterior pituitary bright spot, absent empty sella syndrome , hypoplastic anterior pituitary gland and/or pituitary stalk/infundibulum, and genetically proven biochemical growth hormone deficiency either isolated or as part of hypopituitarism in association with pituitary deficits (ACTH, TSH, GnRH or vasopressin/ADH deficiency); OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGF-1 levels; OR
- Patient must have evidence of biochemical growth hormone deficiency, with a peak serum growth hormone concentration less than 10mU/L in response to 1 growth hormone stimulation test (pharmacological or physiological e.g. arginine, clonidine, glucagon, insulin, sleep, exercise) and low plasma IGFBP-3 levels, **AND**
- Patient must have other hypothalamic/pituitary hormone deficits (includes ACTH, TSH, GnRH and/or vasopressin/ADH deficiencies), **AND**
- Patient must have hypothalamic obesity, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment and a growth velocity above the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a growth velocity above the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less at commencement of growth hormone treatment and an annual growth velocity of 8 cm per year or greater in the twelve month period immediately prior to commencement of growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Evidence of biochemical growth hormone deficiency, including the type of tests performed and peak growth hormone concentrations; AND

5. (a) Confirmation that the patient has a structural lesion that is not neoplastic; OR

(b) Confirmation that the patient had a structural lesion that was neoplastic and has undergone a 12 month period of observation following completion of treatment for the structural lesion (all treatment); OR

(c) Confirmation that the patient has a structural lesion that is neoplastic, has received medical advice that it is unsafe to treat the structural lesion, and has undergone a 12 month period of observation since initial diagnosis of the structural lesion; AND

6. Confirmation that the patient has other hypothalamic/pituitary hormone deficits; AND

7. Confirmation that the patient has hypothalamic obesity; AND

8. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

9. A bone age result performed within the last 12 months; AND

10. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature associated with Turner syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with Turner syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have had a height at or below the 95th percentile for age on the Turner syndrome growth curve for girls immediately prior to commencing growth hormone treatment, **AND**
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in all cells (45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as a loss of a whole X chromosome in some cells (mosaic 46XX/45X), and gender of rearing is female; OR
- Patient must have diagnostic results consistent with Turner syndrome (the condition must be genetically proven), defined as genetic loss or rearrangement of an X chromosome (such as isochromosome X, ring-chromosome, or partial deletion of an X chromosome), and gender of rearing is female, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a bone age of 2.5 years or less, **AND**
- Patient must not have a bone age of 13.5 years or greater, **AND**
- Patient must not have a height greater than or equal to 155.0 cm.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. A height measurement from immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with Turner syndrome; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. A bone age result performed within the last 12 months; AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature due to short stature homeobox (SHOX) gene disorders

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature due to short stature homeobox (SHOX) gene disorders, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as a karyotype confirming the presence of a SHOX mutation/deletion without the presence of mixed gonadal dysgenesis; OR
- Patient must have diagnostic results consistent with a SHOX mutation/deletion, defined as mixed gonadal dysgenesis (45X mosaic karyotype with the presence of any Y chromosome material and/or SRY gene positive by FISH study) and have an appropriate plan of management in place for the patient's increased risk of gonadoblastoma, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity below the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity below the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8 cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height below the 1st percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes (excluding gonadoblastoma secondary to mixed gonadal dysgenesis), **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has diagnostic results consistent with a short stature homeobox (SHOX) gene disorder; AND

5. If the patient's condition is secondary to mixed gonadal dysgenesis, confirmation that an appropriate plan of management for the patient's increased risk of gonadoblastoma is in place; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

8. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature associated with chronic renal insufficiency

Treatment Phase: Continuing treatment as a reclassified patient

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature associated with chronic renal insufficiency, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 9.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must be male, had a chronological age of at least 12 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be male, had a bone age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a chronological age of at least 10 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must be female, had a bone age of at least 8 years at commencement of growth hormone treatment, a growth velocity equal to or less than the 25th percentile for bone age and sex measured over the 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a growth velocity equal to or less than the 25th percentile for bone age and sex measured over both the 12 month and 6 month interval immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment; OR
- Patient must have had a bone age of 2.5 years or less immediately prior to commencement of growth hormone treatment, an annual growth velocity of 8cm per year or less in the twelve month period immediately prior to commencement of growth hormone treatment, and a height equal to or less than the 25th percentile for age and sex immediately prior to commencing growth hormone treatment, **AND**
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, and not have undergone a renal transplant; OR
- Patient must have an estimated glomerular filtration rate less than 30mL/minute/1.73m^2 measured by creatinine clearance, excretion of radionuclides such as DTPA, or by the height/creatinine formula, have undergone a renal transplant, and have undergone a 12 month period of observation following the transplant, **AND**
- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**

- Patient must be male and must not have a height greater than or equal to 167.7cm; OR
- Patient must be female and must not have a height greater than or equal to 155.0cm, **AND**
- Patient must be male and must not have a bone age of 15.5 years or more; OR
- Patient must be female and must not have a bone age of 13.5 years or more.

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) A minimum of 12 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, at intervals no greater than six months, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; OR

(b) If the patient was an older child (males chronological age 12 and over or bone age 10 and over, females chronological age 10 and over or bone age 8 and over) at the time of commencement of growth hormone treatment, a minimum of 6 months of growth data (height and weight) from immediately prior to commencement of growth hormone treatment, and a bone age result performed within the 12 months immediately prior to commencement of growth hormone treatment; AND

4. Confirmation that the patient has an estimated glomerular filtration rate less than 30ml/minute/1.73m^2 ; AND

5. If a renal transplant has taken place, confirmation that the patient has undergone a 12 month period of observation following transplantation; AND

6. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

7. A bone age result performed within the last 12 months; AND

The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note If a patient receiving treatment under the indication short stature due to chronic renal insufficiency undergoes a renal transplant and 12 months post-transplant has an eGFR of equal to or greater than 30mL/min/1.73m^2 prescribers should seek reclassification to the indication short stature and slow growth.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
HOBART TAS 7001

Authority required

Short stature and poor body composition due to Prader-Willi syndrome

Treatment Phase: Continuing treatment as a reclassified patient

Treatment criteria:

- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in paediatric endocrinology; OR
- Must be treated by a medical practitioner in consultation with a nominated specialist or consultant physician in general paediatrics.

Clinical criteria:

- Patient must have previously received treatment under the PBS S100 Growth Hormone Program under a category other than short stature and poor body composition due to Prader-Willi syndrome, **AND**
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a

continuing treatment period, whichever applies), unless response was affected by an adverse reaction to growth hormone; OR

- The treatment must not have lapsed due to failure to respond to growth hormone at a dose of 7.5mg/m^2/week or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems, **AND**
- Patient must have a current bone age below skeletal maturity (15.5 for males and 13.5 for females); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by a significant medical illness; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by major surgery (e.g. renal transplant); OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies) , unless response was affected by an adverse reaction to growth hormone; OR
- Patient must have a current bone age at or above skeletal maturity (15.5 for males and 13.5 for females) and treatment must not have lapsed due to failure to respond to growth hormone at a dose of 0.04mg/kg/wk or greater for the most recent treatment period (32 weeks for an initial or recommencement treatment period and 26 weeks for a continuing treatment period, whichever applies), unless response was affected by non-compliance due to social/family problems,

AND

- Patient must have diagnostic results consistent with Prader-Willi syndrome (the condition must be genetically proven); OR
- Patient must have a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist, **AND**
- Patient must have been evaluated via polysomnography for airway obstruction and apnoea whilst on growth hormone treatment and any sleep disorders identified that required treatment must have been addressed, **AND**
- Patient must not have uncontrolled morbid obesity, defined as a body weight greater than 200% of ideal body weight for height and sex, with ideal body weight derived by calculating the 50th percentile weight for the patient's current height,

AND

- Patient must not have diabetes mellitus, **AND**
- Patient must not have a condition with a known risk of malignancy including chromosomal abnormalities such as Down and Bloom syndromes, **AND**
- Patient must not have an active tumour or evidence of tumour growth or activity, **AND**
- Patient must not have a chronological age of 18 years or greater.

The maximum duration of each continuing treatment phase is 26 weeks. Prescribers must determine an appropriate weekly dose in accordance with the dosing arrangements detailed in the **National Health (Growth Hormone Program) Special Arrangement 2015** and request the appropriate number of vials/cartridges required to provide sufficient drug for 13 weeks' worth of treatment (with up to 1 repeat allowed).

The authority application must be in writing and must include:

1. A completed authority prescription form; AND

2. A completed Growth Hormone Authority Application Supporting Information Form for continuing treatment as a reclassified patient; AND

3. (a) Confirmation that the patient has diagnostic results consistent with Prader-Willi syndrome, OR

(b) Confirmation that the patient has a clinical diagnosis of Prader-Willi syndrome, confirmed by a clinical geneticist; AND

4. Confirmation that the patient has been evaluated via polysomnography for airway obstruction and apnoea whilst on growth hormone treatment, and any sleep disorders identified via the polysomnography that required treatment have been addressed; AND

5. Growth data (height and weight) for the most recent 6 month treatment period, including data at both the start and end of the treatment period. The most recent data must not be older than three months; AND

6. The date that skeletal maturity was achieved (if applicable); AND

7. The proprietary name (brand), form and strength of somatropin requested, and the number of vials/cartridges required to provide sufficient drug for 13 weeks worth of treatment (with up to 1 repeat allowed).

Prescribers must keep a copy of any clinical records relating to the prescription, including such records required to demonstrate that the prescription was written in compliance with any relevant circumstances and/or purposes. These records must be kept for 2 years after the date the prescription to which the records relate is written.

Note Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).
Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Complex Drugs

Reply Paid 9826
HOBART TAS 7001

SOMATROPIN (Recombinant human growth hormone) Powder for injection 5 mg (15 i.u.) with diluent in pre-filled pen (with preservative), 1

10443P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	223.37	39.50	Genotropin GoQuick [PF]

SOMATROPIN (Recombinant human growth hormone) Powder for injection 12 mg (36 i.u.) with diluent in pre-filled pen (with preservative), 1

10431B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin GoQuick [PF]

somatropin 4.8 units (1.6 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10454F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	491.48	39.50	Genotropin MiniQuick [PF]

somatropin 4.2 units (1.4 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10488B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	430.93	39.50	Genotropin MiniQuick [PF]

somatropin 6 units (2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10428W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	612.55	39.50	Genotropin MiniQuick [PF]

somatropin 5.4 units (1.8 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10500P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	552.02	39.50	Genotropin MiniQuick [PF]

somatropin 3 units (1 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10480N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	309.85	39.50	Genotropin MiniQuick [PF]

somatropin 3.6 units (1.2 mg) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10453E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	370.39	39.50	Genotropin MiniQuick [PF]

somatropin 2.4 units (800 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10479M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	249.31	39.50	Genotropin MiniQuick [PF]

somatropin 1.8 units (600 microgram) injection [7] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

10456H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	188.78	39.50	Genotropin MiniQuick [PF]

somatropin 400 microgram injection, syringe [7] (&) inert substance diluent, syringe [7 x 0.25 mL syringes], 1 pack

10891F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	128.23	39.50	Genotropin MiniQuick [PF]

somatropin 36 units (12 mg) injection [1 cartridge] (&) inert substance diluent [1 mL cartridge], 1 pack

10499N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	526.07	39.50	Genotropin [PF]

IVF Treatment Program

GENITO URINARY SYSTEM AND SEX HORMONES 1537

SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM 1537
PROGESTOGENS 1537
GONADOTROPINS AND OTHER OVULATION STIMULANTS 1537

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 1540

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES 1540
HYPOTHALAMIC HORMONES 1540

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 1540

ENDOCRINE THERAPY 1540
HORMONES AND RELATED AGENTS 1540

GENITO URINARY SYSTEM AND SEX HORMONES

SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

PROGESTOGENS

Pregnen (4) derivatives

PROGESTERONE

Authority required (STREAMLINED)

4997

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for luteal phase support as part of an assisted reproductive technology (ART) treatment cycle for infertile women, **AND**
- Patient must be receiving medical services as described in items 13200 or 13201 of the Medicare Benefits Schedule.

The luteal phase is defined as the time span from embryo transfer until implantation confirmed by positive B-hCG measurement.

progesterone 100 mg pessary, 15

9608Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*156.55	39.50	Oripro [ON]

progesterone 200 mg capsule, 42

10930G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	86.68	39.50	Utrogestan [HB]

progesterone 200 mg pessary, 15

9609R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*171.94	39.50	Oripro [ON]

progesterone 100 mg pessary, 21

10116K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*104.99	39.50	Endometrin [FP]

PROGESTERONE

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5045

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for luteal phase support as part of an assisted reproductive technology (ART) treatment cycle for infertile women, **AND**
- Patient must be receiving medical services as described in items 13200 or 13201 of the Medicare Benefits Schedule.

The luteal phase is defined as the time span from embryo transfer until implantation confirmed by positive B-hCG measurement.

progesterone 8% vaginal gel, 15 applications

6366C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*300.59	39.50	Crinone 8% [SG]

GONADOTROPINS AND OTHER OVULATION STIMULANTS

Gonadotropins

CHORIOGONADOTROPIN ALFA

Note Special Pricing Arrangements apply.

Authority required (STREAMLINED)

5019

Assisted Reproductive Technology

Clinical criteria:

- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

choriogonadotropin alfa 250 microgram/0.5 mL injection, 1 dose

6182J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	63.21	39.50	Ovidrel [SG]

▪ CORIFOLLITROPIN ALFA

Authority required (STREAMLINED)

5009

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for controlled ovarian stimulation, **AND**
- Patient must have an antral follicle count of 20 or less, **AND**
- Patient must be receiving medical services as described in items 13200, 13201, or 13202 of the Medicare Benefits Schedule, **AND**
- Patient must be undergoing a gonadotrophin releasing antagonist cycle.

corifollitropin alfa 100 microgram/0.5 mL injection, 0.5 mL syringe

5816D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	412.37	39.50	Elonva [MK]

corifollitropin alfa 150 microgram/0.5 mL injection, 0.5 mL syringe

5817E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	672.57	39.50	Elonva [MK]

▪ FOLLITROPIN ALFA

Authority required (STREAMLINED)

5027

Assisted Reproductive Technology

Clinical criteria:

- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

follitropin alfa 75 units (5.5 microgram)/0.125 mL injection, 5 x 0.125 mL injection devices

10861P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*432.88	39.50	Bemfola [FX]

follitropin alfa 300 units (21.84 microgram)/0.5 mL injection, 0.5 mL cartridge

6431L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*234.21	39.50	Gonal-f Pen [SG]

follitropin alfa 225 units (16.5 microgram)/0.375 mL injection, 5 x 0.375 mL injection devices

10872F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*1275.19	39.50	Bemfola [FX]

follitropin alfa 900 units (65.52 microgram)/1.5 mL injection, 1.5 mL cartridge

6433N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*1684.55	39.50	Gonal-f Pen [SG]

follitropin alfa 300 units (22 microgram)/0.5 mL injection, 5 x 0.5 mL injection devices

10866X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*1684.54	39.50	Bemfola [FX]

follitropin alfa 150 units (11 microgram)/0.25 mL injection, 5 x 0.25 mL injection devices

10873G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*858.61	39.50	Bemfola [FX]

follitropin alfa 450 units (32.76 microgram)/0.75 mL injection, 0.75 mL cartridge

6432M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*347.73	39.50	Gonal-f Pen [SG]

follitropin alfa 450 units (33 microgram)/0.75 mL injection, 5 x 0.75 mL injection devices

10867Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*2503.24	39.50	Bemfola [FX]

▪ FOLLITROPIN ALFA + LUTROPIN ALFA

Authority required (STREAMLINED)

5250

Stimulation of follicular development

Clinical criteria:

- Patient must have severe LH deficiency, **AND**

- Patient must be considered appropriate for treatment with the combination product after titration of FSH and LH after at least one cycle of treatment, **AND**
- Patient must be receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

follitropin alfa 150 units + lutropin alfa 75 units [1 vial] (&) inert substance diluent [1 vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10491E	14	..	..	*2186.95	39.50	Pergoveris [SG]

▪ FOLLITROPIN BETA

Authority required (STREAMLINED)

5027

Assisted Reproductive Technology

Clinical criteria:

- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

follitropin beta 900 units/1.08 mL injection, 1.08 mL cartridge

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
6464F	5	..	..	*2114.10	39.50	Puregon 900 IU/1.08 mL [MK]

follitropin beta 300 units/0.36 mL injection, 0.36 mL cartridge

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
6335K	2	..	..	*303.55	39.50	Puregon 300 IU/0.36 mL [MK]

follitropin beta 600 units/0.72 mL injection, 0.72 mL cartridge

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
6336L	4	..	..	*1159.47	39.50	Puregon 600 IU/0.72 mL [MK]

▪ HUMAN CHORIONIC GONADOTROPHIN

Authority required (STREAMLINED)

6991

Assisted Reproductive Technology

Clinical criteria:

- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

human chorionic gonadotrophin 5000 units injection [1 vial] (&) inert substance diluent [1 mL vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11156E	2	..	..	*27.33	28.54	Pregnyl [MK]

human chorionic gonadotrophin 1500 units injection [3 vials] (&) inert substance diluent [3 x 1 mL vials], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
11154C	1	..	..	41.89	39.50	Pregnyl [MK]

▪ HUMAN MENOPAUSAL GONADOTROPHIN

Authority required (STREAMLINED)

5027

Assisted Reproductive Technology

Clinical criteria:

- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

human menopausal gonadotrophin 600 units injection [1 vial] (&) inert substance diluent [1 mL syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2036E	3	..	..	*835.78	39.50	Menopur 600 [FP]

human menopausal gonadotrophin 1200 units injection [1 vial] (&) inert substance diluent [2 x 1 mL syringes], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2038G	4	..	..	*2171.87	39.50	Menopur 1200 [FP]

▪ LUTROPIN ALFA

Authority required (STREAMLINED)

5251

Stimulation of follicular development

Clinical criteria:

- Patient must have severe LH deficiency, **AND**
- Patient must be receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

lutropin alfa 75 units injection [1 vial] (&) inert substance diluent [1 mL vial], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10465T	14	..	..	*1422.69	39.50	Luveris [SG]

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

HYPOTHALAMIC HORMONES

Gonadotropin-releasing hormones

NAFARELIN

Authority required (STREAMLINED)

5046

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for prevention of premature luteinisation and ovulation, **AND**
- Patient must be undergoing controlled ovarian stimulation, **AND**
- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

nafarelin 200 microgram/actuation nasal spray, 60 actuations

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
5815C	2	..	..	*227.63	39.50	Synarel [PF]

Anti-gonadotropin-releasing hormones

CETRORELIX

Authority required (STREAMLINED)

5046

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for prevention of premature luteinisation and ovulation, **AND**
- Patient must be undergoing controlled ovarian stimulation, **AND**
- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

cetrorelix 250 microgram injection [1 vial] (&) inert substance diluent [1 mL syringe], 1 pack

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9599F	10	..	..	*462.45	39.50	Cetrotide [SG]

GANIRELIX

Authority required (STREAMLINED)

5046

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for prevention of premature luteinisation and ovulation, **AND**
- Patient must be undergoing controlled ovarian stimulation, **AND**
- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

ganirelix 250 microgram/0.5 mL injection, 0.5 mL syringe

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9583J	10	..	..	*462.45	39.50	Orgalutran [MK]

ganirelix 250 microgram/0.5 mL injection, 5 x 0.5 mL syringes

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
9584K	2	..	..	*462.47	39.50	Orgalutran [MK]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ENDOCRINE THERAPY

HORMONES AND RELATED AGENTS

Gonadotropin releasing hormone analogues

▪ TRIPTORELIN

Authority required (STREAMLINED)

5046

Assisted Reproductive Technology

Clinical criteria:

- The treatment must be for prevention of premature luteinisation and ovulation, **AND**
- Patient must be undergoing controlled ovarian stimulation, **AND**
- Patient must be receiving medical services as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule.

triptorelin acetate 100 microgram/mL injection, 7 x 1 mL syringes

10907C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4	..	..	*216.59	39.50	Decapeptyl [FP]

Opiate Dependence Treatment Program

NERVOUS SYSTEM....1543

OTHER NERVOUS SYSTEM DRUGS.... 1543
DRUGS USED IN ADDICTIVE DISORDERS.... 1543

NERVOUS SYSTEM

OTHER NERVOUS SYSTEM DRUGS

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in opioid dependence

BUPRENORPHINE

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Opiate dependence

Treatment Phase: Maintenance and detoxification (withdrawal)

Clinical criteria:

- The treatment must be within a framework of medical, social and psychological treatment.

buprenorphine 400 microgram sublingual tablet, 7

6307Y NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer
1	5.85	Subutex [IR]

buprenorphine 2 mg sublingual tablet, 7

6308B NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer
1	9.98	Subutex [IR]

buprenorphine 8 mg tablet, 7

6309C NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer
1	28.60	Subutex [IR]

BUPRENORPHINE + NALOXONE

Note Buprenorphine with naloxone soluble film and buprenorphine with naloxone sublingual tablet do not meet all the criteria for bioequivalence. Patients being switched between sublingual tablets and soluble films may therefore require a dosage adjustment.

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Opiate dependence

Clinical criteria:

- The treatment must be within a framework of medical, social and psychological treatment.

buprenorphine 2 mg + naloxone 500 microgram sublingual film, 28

9749D NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer
1	46.20	Suboxone Film 2/0.5 [IR]

buprenorphine 8 mg + naloxone 2 mg sublingual film, 28

9750E NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer
1	132.44	Suboxone Film 8/2 [IR]

METHADONE

Caution The risk of drug dependence is high.

Note Care must be taken to comply with the provisions of State/Territory law when prescribing this drug.

Note Shared Care Model:
For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Restricted benefit

Opiate dependence

ODT

methadone hydrochloride 5 mg/mL oral liquid, 1 L

6172W

NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	33.20	[a] Aspen Methadone Syrup [QA]	[a] Biodone Forte [MW]

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

6171T

NP

Max.Qty Packs	Price ex manufacturer $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	7.91	[a] Aspen Methadone Syrup [QA]	[a] Biodone Forte [MW]

Repatriation Pharmaceutical Benefits Scheme

BENEFICIARIES' ENTITLEMENT CARDS AND ELIGIBILITY FOR REPATRIATION PHARMACEUTICAL BENEFITS

Gold card
This card is issued to those veterans of Australia's defence force, their widows/widowers and dependants entitled to treatment for all medical conditions.



White card
A White Card is issued to Australian veterans or mariners under the Veterans' Entitlements Act 1986 with:

- an accepted war or service-caused injury or disease;
- malignant cancer (neoplasia) whether war-caused or not;
- pulmonary tuberculosis whether war-caused or not;
- post-traumatic stress disorder whether war-caused or not; or
- anxiety and/or depression whether war-caused or not.



Orange card
Orange Repatriation pharmaceutical benefits cards are issued to Commonwealth and allied veterans and mariners who:

- have qualifying service from World War I or II and
- are aged 70 or over and
- have been resident in Australia for 10 years or more.



For more information go to the Department of Veterans' Affairs website:
http://www.dva.gov.au

RPBS Explanatory Notes
Introduction

The Australian Repatriation System

- The Australian Repatriation system is based primarily on the principle of compensation to veterans and eligible dependants for injury or death related to war service. In certain cases, treatment is also provided for accepted injuries or conditions that are not service-related or have occurred as a result of other than war service.
- Through the *Veterans' Entitlements Act 1986* the Department of Veterans' Affairs provides programs of compensation, income support and treatment for eligible veterans and their dependants. One of the defined benefits for eligible veterans is the Repatriation Pharmaceutical Benefits Scheme. This range of medications and dressings is more comprehensive than is available through the Pharmaceutical Benefits Scheme.

RPBS prescribing provisions

- Unless otherwise stated, Repatriation Pharmaceutical Benefits Scheme (RPBS) prescriptions must conform with the requirements of Pharmaceutical Benefits Scheme (PBS) prescriptions, as detailed in Section 1 – Explanatory Notes in the *Schedule of Pharmaceutical Benefits* book. The prescriber shall ensure that a prescription contains the following details:
  - the category of benefit, i.e., RPBS, by placing a cross in the relevant box;
  - the patient's full name and address;
  - the prescription date;
  - the DVA file number of the patient as evidence of entitlement;
  - in the case of authority prescriptions, the Authority approval number or the four digit streamlined authority code;
  - the item, form, strength, quantity and directions;
  - the number of repeats, if applicable;
  - indicate when brand substitution is not permitted; and
  - the name, signature, the prescriber number and address of the prescriber.

Prior Approval Arrangements

- The prior approval of the Department is required to prescribe the following:
  - 'Authority required' items (excluding 'Authority required (STREAMLINED)' items) listed in either the PBS or RPBS Schedule;
  - increased quantities and/or repeats of items listed in either the PBS or RPBS Schedule;
  - items listed under section 100 of the *National Health Act 1953*; and
  - other items not listed in either Schedule (non-Schedule items).
- The above items are to be prescribed on the common PBS/RPBS authority prescription form in accordance with the directions stated in the Explanatory Notes in the *Schedule of Pharmaceutical Benefits* (See also information regarding dental prescribing and prescribing by optometrists under the RPBS in these Notes.)
- All Authority required prescriptions and requests for non-Schedule items must receive prior approval from the Department. This can be achieved by either:
  - using the Department's national free call number 1800 552 580; or
  - by mailing the written authority prescription to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) at the reply paid address shown at the end of these RPBS Explanatory Notes.

Prior approval is not required from DVA to prescribe an Authority required (STREAMLINED) item (except where increased quantities and/or repeats are required). Instead the authority prescription form must include a four digit streamlined authority code.

- Some requests for prior approval (including some non-Schedule items) need to be referred by VAPAC to the Repatriation Pharmaceutical Reference Committee for consideration. In such cases a VAPAC pharmacist will advise the prescriber to submit a request in writing that provides the following information:
  - A current clinical report on the patient's condition (such as age, co-morbidities, renal, liver failure) and clinical reports including pathology, biochemistry, diagnostic and other investigations if appropriate.
  - Details of past and current therapy for the condition. Include details of PBS, RPBS and non-Schedule items utilised, and the results of those therapies.
  - Details of the proposed treatment regimen. Include intended dose and duration of treatment and objective measures of response.
  - When the proposed use of the item is outside the TGA-approved indications for use in Australia, provide copies of articles from peer reviewed publications supporting the proposed treatment.
  - Signed, informed patient consent where the item is to be used for a non-TGA-approved indication.
  - For items without Australian marketing approval, a copy of the TGA Special Access Scheme approval to prescribe the drug.
- Requests for prior approval to prescribe a non-Schedule (PBS or RPBS) item that is of the same therapeutic class (ATC level 3) as an item that is listed on the Schedule, will not be approved unless unequivocal clinical evidence is presented to demonstrate that the requested item is essential for effective treatment of the nominated patient.
- A pharmacist should not supply an item prescribed on an RPBS Authority Prescription Form unless the form has been approved and stamped by VAPAC, or has been endorsed by the prescriber with a telephone Authority approval number provided by VAPAC. Medicare Australia will not accept RPBS Authority prescriptions that have not been approved by the Department of Veterans' Affairs for payment.

Palliative Care Drugs

- The following medications may be available, or made available in increased quantities or doses under prior approval arrangements for use only in the palliative care of terminal disease:
  - clonazepam
  - cyclizine
  - dexamethasone

- disodium pamidronate
- fentanyl
- glycopyrrolate
- hyoscine butylbromide
- hyoscine hydrobromide
- ketamine
- midazolam
- octreotide

- For further information telephone VAPAC on 1800 552 580.

Dental Prescribing

- Under Department of Veterans' Affairs arrangements, financial responsibility for pharmaceutical benefits prescribed by a Local Dental Officer (LDO) is limited to treatment to which holders of the following cards are entitled: Where possible the LDO shall prescribe in accordance with the provisions governing dental prescribing under the Pharmaceutical Benefits Scheme (PBS).
  - a Gold Repatriation Health Card – For All Conditions; or
  - a White Repatriation Health Card – For Specific Conditions; or
  - an Orange Repatriation Pharmaceutical Benefits Card.
- Prescriptions for PBS Dental Schedule items for Gold, White and Orange Card holders are to be dispensed at the PBS concessional rate. Claims for payment by the dispensing pharmacist are to be included with other Repatriation prescriptions. The card holder is required to meet the cost of any applicable brand premium.
- When a non-PBS Dental Schedule item is prescribed for an eligible card holder, the LDO's private prescription form should be used. The dispensing pharmacist may charge the patient the full cost of the prescription. The patient may claim a refund for the full cost of a non-Schedule item from the Department if an itemised receipt (not a cash register receipt) and a copy of the prescription are provided.

Prescribing by optometrists

- Optometrists approved as 'PBS prescribers' may write RPBS prescriptions as outlined in Section 1 for medicines listed in Section 2 of the PBS Schedule as pharmaceutical benefits for optometrical use.
- Medicines in the optometrist list include non-Authority and Authority required items. Procedures for obtaining VAPAC approval to prescribe 'Authority required' optometrist items or increased quantities and/or repeats of optometrist items under the RPBS are the same as indicated under prior approval arrangements above.
- The list of medicines for prescribing by optometrists under the RPBS is the same as applies under the PBS. There are no optometrist listings in the RPBS Schedule for prescribing for veterans only. There is no provision for optometrist prescribers to request approval to prescribe items that are not included in the PBS optometrist list (non-Schedule items).
- Optometrist PBS/RPBS prescription forms are for use for prescribing non-Authority or Authority required optometrist items under the RPBS with one item per form only.

Provisions governing pricing and payment for RPBS benefits

Introduction

- Unless otherwise stated, the pricing and payment principles and arrangements for approved pharmacists supplying pharmaceutical benefits under the RPBS will be the same as those arrangements applying under the PBS.
- Where a pharmaceutical benefit that is not listed on the PBS or RPBS Schedule is dispensed on an RPBS Authority prescription, a pharmacist will price the benefit and enter the serial number, prescription identifying number and price on the sticker or stamp imprint affixed to the prescription.

Pricing of Schedule Items

- Items supplied under the RPBS from the PBS Schedule, both ready-prepared and extemporaneously-prepared, will be paid on the same basis as benefits supplied under the PBS. Items supplied under the RPBS from the Repatriation Schedule, including wound dressings, will be paid on the basis of the price as given in the Repatriation Pharmaceutical Benefits section (Section 1 – RPBS Schedule, Drugs, Medicines and Dressings) of the *Schedule of Pharmaceutical Benefits*.

Pricing of Non-Schedule Ready Prepared Items

- Non-Schedule ready-prepared items are to be priced on the basis of the invoiced, GST-exclusive wholesale price to pharmacists plus the appropriate PBS mark-up and the PBS dispensing fee. Where the item price to pharmacists is greater than $100.00, a copy of the invoice pertaining to the supply of that item is to be submitted together with the appropriate copy of the authority prescription as part of the claim for payment.

Pricing of Non-Schedule Extemporaneously Prepared Items

- When an ingredient drug is not listed in the PBS Drug Tariff, the recovery price will be based on the invoiced wholesale price to pharmacists, increased by a mark-up of 100%, calculated in accordance with the directions contained in the pricing instructions for pricing of PBS extemporaneously-prepared benefits in this Schedule. The price paid by the pharmacist for the commercial pack from which the ingredient is used shall be endorsed on the prescription form.

Miscellaneous Pricing Rules

- The price to pharmacists used as the basis of pricing will be the invoiced, GST-exclusive price from the wholesaler.
- If multiple quantities of a manufacturer's original pack are supplied, the PBS mark-up is applied to the price to pharmacist of each pack and then totalled. The PBS dispensing fee, and the PBS dangerous drug fee if applicable, are then added to the total of the marked-up prices.
- When the quantity prescribed corresponds with the quantity of a manufacturer's original pack, in no circumstances will the price payable for one pack exceed that payable for multiples or combinations of packs to supply the quantity prescribed.

- The list of ingredient drugs and prices included in the PBS Drug Tariff are common to both the PBS and RPBS. Certain restrictions apply regarding the prescribing and dispensing of some of these ingredient drugs as pharmaceutical benefits, e.g., use as additive only.
- For items prescribed generically, including non-Schedule and wound dressings, the pharmacist should indicate on the prescription the quantity and brand supplied. If prescriptions are not endorsed, the Department will pay the lowest priced acceptable product available.

General

Packaging Material, Postage or Freight

- Payment to a pharmacist for the costs of packaging materials, postage or freight required to supply a pharmaceutical benefit is to be paid by the patient, who may then claim reimbursement from the Department through the provision of a pharmacists itemised receipt.

Payment for Items Supplied at Short Intervals

- For all items dispensed at specific short intervals of time, the Department will pay a separate PBS dispensing fee for each occasion that the drug is supplied and which is acknowledged on receipt by the patient or agent.
- The price payable on the items supplied will be based on the individual dose quantity supplied. Where applicable, a PBS dangerous drug fee and a minimum container charge will be payable for each supply.

Receipts for Patient Charges

- Where a charge is paid by a patient in any of the circumstances of paragraphs 13 or 24, the pharmacist is required to provide a printed receipt to the patient with the details of the items or services provided, the amount paid, date of supply and the patients name and address. The patient may apply for reimbursement from the Department.

Special Patient Contributions

- The Special Patient Contribution for items listed as Special Pharmaceutical Benefits in the PBS Schedule is not payable by veterans entitled to pharmaceutical benefits under the RPBS. Eligible veterans receiving Special Pharmaceutical Benefits under the RPBS are required to pay only the concessional patient contribution and any applicable brand premium. If a Safety Net Entitlement card is held, the veteran should receive a Special Pharmaceutical Benefit free of charge, subject to any brand premium applicable. Medicare Australia will reimburse the dispensing pharmacist the total dispensed price, less the concessional patient contribution and/or brand premium if applicable.

Therapeutic Group Premiums — Authority Processing

- Items attracting a therapeutic group premium are dual listed. Dispensing pharmacists are therefore required to select the appropriate code for those items that are dual listed as authority and non-authority items, in order to correctly charge the patient and claim from Medicare Australia. Those authority prescriptions that grant exemption from a therapeutic group premium will have the letters 'TPX' at the beginning of the telephone Authority approval number, or, in the case of a written approval, will be stamped with the words "This prescription does not attract a therapeutic group premium".

Contact the Department of Veterans' Affairs

Authority Prescription Applications

Applications for authority to prescribe under the Repatriation Pharmaceutical Benefits Scheme (RPBS) should be sent to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) using the free postal service:

REPLY PAID 9998
VAPAC (Veterans' Affairs Pharmaceutical Advisory Centre)
Department of Veterens' Affairs
GPO Box 9998
BRISBANE QLD 4001

For RPBS enquiries and telephone approvals 24 hours a day the Freecall number is: 1800 552 580
Departmental pharmacists answer applications for prior approval for non-Schedule items and Authority application calls.

Wound Assessment and Dressing Identification

It is essential to define the aetiology of the wound before selecting a dressing. Recommendations are based on wound type, colour of wound base, depth of wound, and amount of exudate.
This wound chart adheres to the MOIST WOUND concept of healing and wound dressings are described below as ABSORBING or MOISTURE DONATING.
Most wound healing products are designed to remain in situ for several days, with the exception of those for infected wounds which should be changed daily. The quantities and repeats listed in the Repatriation Schedule are considered to be adequate to manage the treatment of a wound for two weeks to one month, when an assessment of the wound's healing process should be undertaken.

DRESSINGS

Pink Epithelialising Wound

Aim: To protect and promote epithelialisation. Epithelialising wounds normally are superficial and only produce a light exudate.

(A) Covering	○ Film; ○ Film Island	○ Gauze—Paraffin; ○ Non-adherent
(B) Absorbing	○ Foam (Light Exudate); ○ Hydroactive (Superficial Wound—Light Exudate)	○ Hydrocolloid (Superficial Wound—Light Exudate)

Red Granulating Wound

Aims: (1) to protect the granulating tissue; (2) to encourage epithelialisation; (3) to absorb excess exudate.

LIGHT EXUDATE:	Superficial	Cavity
(A) Absorbing	○ Foam (Light Exudate); ○ Hydroactive (Superficial Wound—Light Exudate); ○ Hydrocolloid (Superficial Wound—Light Exudate)	○ Hydrocolloid (Cavity Wound)
(B) Moisture donating	○ Hydrogel—Amorphous; ○ Hydrogel—Sheet	○ Hydrogel—Amorphous
HIGH EXUDATE:	Superficial	Cavity
(A) Absorbing	○ Alginate (Superficial Wound); ○ Foam—Heavy Exudate; ○ Hydroactive (Superficial Wound—Moderate Exudate); ○ Hydrocolloid (Superficial Wound—Moderate/High Exudate)	○ Alginate (Cavity Wound); ○ Foam—Moderate Exudate (see “cavity conforming” product); ○ Hydroactive (Cavity Wound); ○ Hydrocolloid (Cavity Wound)
(B) Moisture donating	NOT APPROPRIATE	

Yellow Sloughy Wound

Aims: (1) to remove slough; (2) to encourage granulation; (3) to absorb excess exudate.

LIGHT EXUDATE:	Superficial	Cavity
(A) Absorbing	○ Cadexomer Iodine; ○ Foam—Light Exudate; ○ Foam with Charcoal; ○ Hydroactive (Superficial Wound—Moderate Exudate); ○ Hydrocolloid (Superficial Wound—Moderate Exudate)	○ Cadexomer Iodine; ○ Hydrocolloid (Cavity Wound)
(B) Moisture Donating	○ Hydrogel—Amorphous; ○ Hydrogel—Sheet	○ Hydrogel—Amorphous
HIGH EXUDATE:	Superficial	Cavity
(A) Absorbing	○ Alginate (Superficial Wound); ○ Cadexomer Iodine; ○ Foam—Heavy Exudate; ○ Hydroactive (Superficial Wound—Moderate/High Exudate); ○ Hydrocolloid (Superficial Wound—Moderate/High Exudate)	○ Alginate (Cavity Wound); ○ Cadexomer Iodine; ○ Hydrocolloid (Cavity Wound)
(B) Moisture donating	NOT APPROPRIATE	

Black Necrotic Wound
Aims: To remove eschar by — (1) sharp debridement, e.g., scissor/scalpel and/or (2) rehydration and autolytic debridement. (These wounds usually produce a LIGHT EXUDATE.)

DRY / LIGHT EXUDATE:	Superficial	Cavity
(A) Absorbing	○ Hydroactive (Superficial Wound—Light Exudate); ○ Hydrocolloid (Superficial Wound—Light/Moderate Exudate)	○ Hydrocolloid (Cavity Wound)
(B) Moisture donating	○ Hydrogel—Amorphous; ○ Hydrogel—Sheet	○ Hydrogel—Amorphous; ○ Hydrogel—Sheet

Infected Wounds
Aims: (1) to clear the infection with systemic antibiotics; (2) to absorb excess exudate; (3) to remove slough if present; (4) to decrease bacterial burden - by applying a Silver dressing or Cadexomer Iodine dressing.

Malodorous Wounds
Aims: (1) to clear infection if present; (2) to remove slough if present; (3) to clear colonising odour-producing bacteria **in** slough — by applying metronidazole gel, a Silver dressing or a Cadexomer Iodine dressing; (4) to absorb excess exudate.
Products: Activated Charcoal; Alginate with Charcoal; Foam with Charcoal; Silver dressing; Cadexomer Iodine dressing.

Minor Skin Trauma
Aims: (1) to stop bleeding; (2) to prevent infection; (3) to minimise the surface defect; (4) to promote epithelialisation.

Ordering Products

Ordering Coloplast Products
Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

Ordering Hartmann Products
Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

Ordering Molnlycke Healthcare Products
Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

Ordering Smith & Nephew Products
Smith & Nephew products are distributed via the three major wholesalers, API, SIGMA & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

ALIMENTARY TRACT AND METABOLISM 1554

STOMATOLOGICAL PREPARATIONS 1554
STOMATOLOGICAL PREPARATIONS 1554
DRUGS FOR ACID RELATED DISORDERS 1554
ANTACIDS 1554
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS 1554
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS 1554
BELLADONNA AND DERIVATIVES, PLAIN 1554
DRUGS FOR CONSTIPATION 1555
DRUGS FOR CONSTIPATION 1555
ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS 1556
ELECTROLYTES WITH CARBOHYDRATES 1556
ANTIPROPULSIVES 1556
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS 1556
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS 1556
VITAMINS 1557
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12 1557
VITAMIN B-COMPLEX, INCL. COMBINATIONS 1557
MINERAL SUPPLEMENTS 1557
CALCIUM 1557
OTHER MINERAL SUPPLEMENTS 1558

BLOOD AND BLOOD FORMING ORGANS 1558

ANTITHROMBOTIC AGENTS 1558
ANTITHROMBOTIC AGENTS 1558
ANTIANEMIC PREPARATIONS 1559
IRON PREPARATIONS 1559
VITAMIN B12 AND FOLIC ACID 1559
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS 1560
IRRIGATING SOLUTIONS 1560

CARDIOVASCULAR SYSTEM 1560

VASOPROTECTIVES 1560
AGENTS FOR TREATMENT OF HEMORRHOIDS AND ANAL FISSURES FOR TOPICAL USE 1560

DERMATOLOGICALS 1560

ANTIFUNGALS FOR DERMATOLOGICAL USE 1560
ANTIFUNGALS FOR TOPICAL USE 1560
ANTIFUNGALS FOR SYSTEMIC USE 1561
EMOLLIENTS AND PROTECTIVES 1561
EMOLLIENTS AND PROTECTIVES 1561
PROTECTIVES AGAINST UV-RADIATION 1562
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC. 1563
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC. 1563
ANTIPSORIATICS 1563
ANTIPSORIATICS FOR TOPICAL USE 1563
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE 1563

ANTIBIOTICS FOR TOPICAL USE ... 1563
CHEMOTHERAPEUTICS FOR TOPICAL USE ... 1563
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS ... 1564
CORTICOSTEROIDS, PLAIN ... 1564
ANTISEPTICS AND DISINFECTANTS ... 1564
ANTISEPTICS AND DISINFECTANTS ... 1564
OTHER DERMATOLOGICAL PREPARATIONS ... 1564
OTHER DERMATOLOGICAL PREPARATIONS ... 1564

GENITO URINARY SYSTEM AND SEX HORMONES ... 1566

GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS ... 1566
ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS ... 1566
OTHER GYNECOLOGICALS ... 1567
OTHER GYNECOLOGICALS ... 1567
UROLOGICALS ... 1567
UROLOGICALS ... 1567
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY ... 1568

ANTIINFECTIVES FOR SYSTEMIC USE ... 1570

ANTIBACTERIALS FOR SYSTEMIC USE ... 1570
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS ... 1570

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS ... 1570

ANTINEOPLASTIC AGENTS ... 1570
ANTIMETABOLITES ... 1570
IMMUNOSUPPRESSANTS ... 1570
IMMUNOSUPPRESSANTS ... 1570

MUSCULO-SKELETAL SYSTEM ... 1571

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN ... 1571
TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN ... 1571
DRUGS FOR TREATMENT OF BONE DISEASES ... 1571
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION ... 1571

NERVOUS SYSTEM ... 1573

ANALGESICS ... 1573
OPIOIDS ... 1573
OTHER ANALGESICS AND ANTIPYRETICS ... 1573
PSYCHOLEPTICS ... 1574
ANXIOLYTICS ... 1574
HYPNOTICS AND SEDATIVES ... 1575
OTHER NERVOUS SYSTEM DRUGS ... 1576
DRUGS USED IN ADDICTIVE DISORDERS ... 1576

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS ... 1576

ANTHELMINTICS ... 1576
ANTINEMATODAL AGENTS ... 1576

RPBS

RESPIRATORY SYSTEM....1576

NASAL PREPARATIONS.... 1576
DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE.... 1576
NASAL DECONGESTANTS FOR SYSTEMIC USE.... 1577

COUGH AND COLD PREPARATIONS.... 1577
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS.... 1577
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS.... 1577

ANTIHISTAMINES FOR SYSTEMIC USE.... 1578
ANTIHISTAMINES FOR SYSTEMIC USE.... 1578

SENSORY ORGANS....1578

OPHTHALMOLOGICALS.... 1578
DECONGESTANTS AND ANTIALLERGICS.... 1578

OTOLOGICALS.... 1579
OTHER OTOLOGICALS.... 1579

VARIOUS....1579

ALL OTHER THERAPEUTIC PRODUCTS.... 1579
ALL OTHER THERAPEUTIC PRODUCTS.... 1579

GENERAL NUTRIENTS.... 1579
OTHER NUTRIENTS.... 1579

ALL OTHER NON-THERAPEUTIC PRODUCTS.... 1580
ALL OTHER NON-THERAPEUTIC PRODUCTS.... 1580

RPBS

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antiinfectives and antiseptics for local oral treatment

CHLORHEXIDINE

chlorhexidine gluconate 0.2% mouthwash, 300 mL

4204G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.79	6.40	Savacol Mouth and Throat Rinse [OM]

chlorhexidine gluconate 0.2% mouthwash, 250 mL

4161B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.85	6.40	Plaqacide [OB]

NYSTATIN

nystatin 100 000 units/mL oral liquid, 24 mL

10854G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	17.57	6.40	[a] Pharmacy Action Nystatin Oral Drops [GQ]
			..	18.81	6.40	[a] Mycostatin Oral Drops [QA]

DRUGS FOR ACID RELATED DISORDERS

ANTACIDS

Calcium compounds

CALCIUM CARBONATE + GLYCINE

Note For patients with chronic renal failure.

calcium carbonate 420 mg + glycine 180 mg chewable tablet, 100

4055K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*25.67	6.40	Titralac [MM]

Combinations and complexes of aluminium, calcium and magnesium compounds

ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE

ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Oral suspension 400 mg-400 mg-30 mg per 5 mL, 500 mL, 1

4118R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*25.19	6.40	Mylanta Double Strength [JT]

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Synthetic anticholinergics, esters with tertiary amino group

MEBEVERINE

mebeverine hydrochloride 135 mg tablet, 90

4328T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	28.91	6.40	[a] Colese [AF]
			..	33.41	6.40	[a] Colofac [GO]

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, semisynthetic, quaternary ammonium compounds

HYOSCINE BUTYLBROMIDE

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

4279F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	23.43	6.40	Buscopan [VZ]

RPBS

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Softeners, emollients

DOCUSATE

docusate sodium 50 mg tablet, 100

4200C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	17.95	6.40	Coloxyl 50 [FM]

Contact laxatives

BISACODYL

bisacodyl 10 mg suppository, 12

10580W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	4	..	*21.43	6.40	Petrus Bisacodyl Suppositories [PP]

bisacodyl 10 mg suppository, 10

10578R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*23.71	6.40	[a] Petrus Bisacodyl Suppositories [PP]
			..	*25.00	6.40	[a] Dulcolax [VZ]

DOCUSATE + SENNOSIDE B

docusate sodium 50 mg + sennoside B 8 mg tablet, 100

4028B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	18.04	6.40	Soflax [EA]

docusate sodium 50 mg + sennoside B 8 mg tablet, 90

10177P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	2	..	16.93	6.40	Pharmacy Action Laxative with Senna [GQ]

DOCUSATE + SENNOSIDES

docusate sodium 50 mg + sennosides 11.27 mg tablet, 90

4198Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	16.97	6.40	[a] Chemists' Own Laxative with Senna [RW]	[a] Colaxsen [QA]
						[a] Co-Senna [PP]	
			..	20.02	6.40	[a] Coloxyl with Senna [FM]	

SENNOSIDE B

sennoside B 7.5 mg tablet, 100

4455L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	16.46	6.40	[a] Senna-Gen [PP]
			..	17.56	6.40	[a] Senokot [RC]

Bulk-forming laxatives

DRY PSYLLIUM HUSK

dry psyllium husk 3.5 g powder for oral liquid, 30 sachets

4285M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	20.85	6.40	Fybogel [RC]

PSYLLIUM HUSK POWDER

PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (orange-flavoured, sugar-free) 283 g, 1

4419N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	24.35	6.40	Metamucil Orange Smooth [PY]

PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (non-flavoured) 336 g, 1

4422R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	21.18	6.40	Fibre Health Natural Granular [PP]

RPBS

			..	24.35	6.40	Metamucil Natural Granular [PY]

▪ RHAMNUS FRANGULA + STERCULIA

rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g

4558X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	27.57	6.40	Normacol Plus [NE]

Enemas

▪ SORBITOL + CITRIC ACID + LAURYL SULFOACETATE SODIUM

sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 4 x 5 mL

4462W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	16.03	6.40	Micolette [AE]

Other drugs for constipation

▪ GLYCEROL

glycerol 1.4 g suppository, 12

10596Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*23.32	6.40	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 2.8 g suppository, 12

4246L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*23.80	6.40	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 700 mg suppository, 12

10586E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	5	..	*22.96	6.40	Petrus Pharmaceuticals Pty Ltd [PP]

▪ ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS

ELECTROLYTES WITH CARBOHYDRATES

Oral rehydration salt formulations

▪ SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE MONOHYDRATE + CITRIC ACID

sodium chloride 470 mg + potassium chloride 300 mg + glucose monohydrate 3.56 g + sodium acid citrate 530 mg powder for oral liquid, 10 x 4.9 g sachets

10574M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.90	6.40	restore O.R.S. [EA]

ANTIPROPULSIVES

Antipropulsives

▪ LOPERAMIDE

loperamide hydrochloride 2 mg capsule, 20

11135C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	12.58	6.40	Pharmacy Action Diarrhoea Relief [GQ]

loperamide hydrochloride 2 mg capsule, 12

10592L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	12.58	6.40	Gastrex [CR]

▪ ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS

ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS

Peripherally acting antiobesity products

▪ ORLISTAT

Note The patient should be ideally enrolled in an exercise program and be receiving supplemental vitamins.

Authority required

Obesity

RPBS

Treatment Phase: Initial treatment

Clinical criteria:

- Patient must have a Body Mass Index (BMI) greater than or equal to 35 with no known co-morbidities; OR
- Patient must have a BMI greater than or equal to 30 with 1 or more of the following co-morbidities;(i) diabetes;(ii) ischaemic heart disease;(iii) psychiatric conditions;(iv) hypertension, **AND**
- Patient must be receiving, or enrolled to receive, professional dietetic and weight management advice (where this is available), **AND**
- The treatment must not exceed 12 months in total from initial application, **AND**
- Patient must not receive more than 1 continuous treatment in a lifetime.

The prescriber must provide the patient's initial body weight and BMI at the time of application.

Authority required

Obesity

Treatment Phase: Continuing treatment (3 to 6 months following commencement)

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must have reduced their inital body weight by 2.5 kg or 2.5% (whichever is the lesser) during the period 3 to 6 months following commencement of treatment with this drug, **AND**
- The treatment must not exceed 12 months in total from initial application, **AND**
- Patient must not receive more than 1 continuous treatment in a lifetime, **AND**
- Patient must be receiving, or enrolled to receive, professional dietetic and weight management advice (where this is available).

Authority required

Obesity

Treatment Phase: Continuing treatment (6 to 12 months following commencement)

Clinical criteria:

- Patient must have previously been issued with an authority prescription for this drug, **AND**
- Patient must have reduced their inital body weight by 5 kg or 5% (whichever is the lesser) during the period 6 to 12 months following commencement of treatment with this drug, **AND**
- The treatment must not exceed 12 months in total from initial application, **AND**
- Patient must not receive more than 1 continuous treatment in a lifetime, **AND**
- Patient must be receiving, or enrolled to receive, professional dietetic and weight management advice (where this is available).

orlistat 120 mg capsule, 84

4570M

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	132.67	6.40	Xenical [RO]

▪ VITAMINS

VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12

Vitamin B1, plain

▪ THIAMINE

thiamine hydrochloride 100 mg tablet, 100

4043T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	2	..	14.98	6.40	Betavit [PP]

VITAMIN B-COMPLEX, INCL. COMBINATIONS

Vitamin B-complex, plain

▪ FERRIC PYROPHOSPHATE + THIAMINE + PYRIDOXINE + CYANOCOBALAMIN + LYSINE

cyanocobalamin 25 microgram/10 mL + iron (as ferric pyrophosphate) 10 mg/10 mL + lysine hydrochloride 300 mg/10 mL + pyridoxine hydrochloride 5 mg/10 mL + thiamine hydrochloride 10 mg/10 mL oral liquid, 200 mL

4493L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	2	..	17.11	6.40	Accomin Adult Tonic [PF]

▪ MINERAL SUPPLEMENTS

CALCIUM

Calcium

▪ CALCIUM

Restricted benefit

Hyperphosphataemia

Clinical criteria:

- The condition must be associated with chronic renal failure.

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

4094L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	4	1	..	*29.67	6.40	Cal-500 [PP]

CALCIUM Tablet 600 mg (as carbonate), 120

4142B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*24.13	6.40	CAL-600 [PP]

▪ CALCIUM

Restricted benefit
Hypocalcaemia
Restricted benefit
Osteoporosis
Restricted benefit
Proven calcium malabsorption

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

4333C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*20.37	6.40	Cal-500 [PP]

CALCIUM Tablet 600 mg (as carbonate), 120

4082W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	17.61	6.40	CAL-600 [PP]

OTHER MINERAL SUPPLEMENTS

Magnesium

▪ MAGNESIUM ASPARTATE DIHYDRATE

Restricted benefit
Hypomagnesaemia
The condition must be documented in the patient's medical records.

magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50

4321K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	17.11	6.40	Mag-Sup [PP]
			..	17.68	6.40	Magmin [BB]

▪ BLOOD AND BLOOD FORMING ORGANS

▪ ANTITHROMBOTIC AGENTS

ANTITHROMBOTIC AGENTS

Platelet aggregation inhibitors excl. heparin

▪ ASPIRIN

aspirin 100 mg tablet, 90

4076M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	19.13	6.40	Cardiprin 100 [RC]

aspirin 100 mg tablet, 112

10590J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	12.93	6.40	Spren 100 [OW]

▪ ASPIRIN

Note The enteric coated preparations are for patients with a significant risk of gastrointestinal bleeding.

aspirin 100 mg enteric capsule, 84

4078P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	18.22	6.40	Astrix [YN]

aspirin 100 mg enteric tablet, 84

4077N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	17.43	6.40	Cardasa [AF]	

					[a] Cartia [AS]	[a] Pharmacy Action Low Dose Aspirin [GQ]

▪ CLOPIDOGREL

Note Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

Authority required

For use in patients pre- and post-angioplasty

clopidogrel 75 mg tablet, 28

10169F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	15.18	6.40	[a] Clopidogrel GH [GQ]	[a] Plidogrel [RF]

clopidogrel 75 mg tablet, 28

4179Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	3	..	15.18	6.40	[a] APO-Clopidogrel [TX]	[a] Blooms the Chemist Clopidogrel [IB]
					[a] Chem mart Clopidogrel [CH]	[a] Clopidogrel AN [EA]
					[a] Iscover [AV]	[a] Piax [AF]
					[a] Plavix [SW]	[a] Terry White Chemists Clopidogrel [TW]

▪ ANTIANEMIC PREPARATIONS

IRON PREPARATIONS

Iron bivalent, oral preparations

▪ FERROUS FUMARATE

ferrous fumarate 200 mg (equivalent to 65.7 mg of elemental iron) tablet, 60

10594N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	17.76	6.40	Ferro-tab [AE]

Iron in combination with folic acid

▪ FERROUS FUMARATE + FOLIC ACID

ferrous fumarate 310 mg (equivalent to 100 mg elemental iron) + folic acid 350 microgram tablet, 60

10579T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	1	..	18.78	6.40	Ferro-f-tab [AE]

VITAMIN B12 AND FOLIC ACID

Vitamin B12 (cyanocobalamin and analogues)

▪ HYDROXOCOBALAMIN

Note One injection of hydroxocobalamin 1 mg every three months provides appropriate maintenance therapy in vitamin B_{12} deficiencies.

Note Pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as acetate) in 1 mL and pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as chloride) in 1 mL are equivalent for the purposes of substitution.

Restricted benefit

Pernicious anaemia

Restricted benefit

Proven vitamin B12 deficiencies other than pernicious anaemia

Restricted benefit

Anaemias associated with vitamin B12 deficiency

Clinical criteria:

- Patient must have had a gastrectomy, **AND**
- The treatment must be for prophylaxis.

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

10577Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	15.36	6.40	[a] Vita-B12 [GH]

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

10587F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	..	..	15.36	6.40	[a] Neo-B12 [PF]

Folic acid and derivatives

▪ FOLIC ACID

folic acid 500 microgram tablet, 100

10584C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*15.15	6.40	[a] Foltabs 500 [PP]	[a] Megafol 0.5 [AF]

▪ FOLIC ACID

Note The 5 mg strength tablet should be used in malabsorption states only.

folic acid 5 mg tablet, 100

10573L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*17.37	6.40	Megafol 5 [AF]

▪ BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS

IRRIGATING SOLUTIONS

Salt solutions

▪ SODIUM CHLORIDE

sodium chloride 0.9% (9 g/L) solution, 1 L bottle

4461T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	14.77	6.40	Baxter Healthcare Pty Ltd [BX]

sodium chloride 0.9% (4.5 g/500 mL) solution, 500 mL bottle

4460R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	14.49	6.40	Baxter Healthcare Pty Ltd [BX]

▪ CARDIOVASCULAR SYSTEM

▪ VASOPROTECTIVES

AGENTS FOR TREATMENT OF HEMORRHOIDS AND ANAL FISSURES FOR TOPICAL USE

Other agents for treatment of hemorrhoids and anal fissures for topical use

▪ ZINC OXIDE + PERU BALSAM + BENZYL BENZOATE

zinc oxide 10.75% + peru balsam 1.88% + benzyl benzoate 1.25% ointment, 50 g

4039N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	18.06	6.40	Anusol [JT]

zinc oxide 300 mg + peru balsam 50 mg + benzyl benzoate 33 mg suppository, 12

4040P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	17.12	6.40	Anusol [JT]

▪ DERMATOLOGICALS

▪ ANTIFUNGALS FOR DERMATOLOGICAL USE

ANTIFUNGALS FOR TOPICAL USE

Antibiotics

▪ NYSTATIN

nystatin 100 000 units/g cream, 15 g

4001N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	16.10	6.40	Mycostatin [FM]

Imidazole and triazole derivatives

▪ CLOTRIMAZOLE

clotrimazole 1% cream, 20 g

4004R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	12.85	6.40	[a] Pharmacy Action Anti-Fungal Cream [GQ]
			..	13.19	6.40	[a] Clonea [AF]

▪ KETOCONAZOLE

Restricted benefit

Severe seborrhoeic dermatitis

ketoconazole 2% shampoo, 100 mL

4007X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	22.35	6.40	Sebizole [EA]

▪ MICONAZOLE

miconazole nitrate 2% cream, 40 g

3400Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	17.40	6.40	Resolve Thrush [EO]

Other antifungals for topical use

▪ AMOROLFINE

Restricted benefit

Onychomycosis

amorolfine 5% application, 5 mL

4010C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	47.65	6.40	[a] Myconail [AE]
			..	61.08	6.40	[a] Sandoz Nail Repair [SZ]
			..	67.73	6.40	[a] Pharmacy Action Anti-Fungal Nail Treatment [GQ]
			..	83.90	6.40	[a] Aporyl [TX]
			..	92.65	6.40	[a] Loceryl [GA]

▪ TERBINAFINE

Restricted benefit

Tinea pedis

terbinafine 1% gel, 15 g

4463X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	25.81	6.40	Lamisil DermGel [GK]

terbinafine hydrochloride 1% cream, 15 g

4473K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	1	..	24.54	6.40	[a] Lamisil [GK]	[a] Pharmacy Action Pharmisil [GQ]

▪ TOLNAFTATE

tolnaftate 0.07% spray, 100 g

4481W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.63	6.40	Tinaderm [BN]

ANTIFUNGALS FOR SYSTEMIC USE

Antifungals for systemic use

▪ TERBINAFINE

Authority required

Onychomycosis

Clinical criteria:

- The condition must be due to dermatophyte infection proven by microscopy and confirmed by an Approved Pathology Provider; OR
- The condition must be due to dermatophyte infection proven by culture and confirmed by an Approved Pathology Provider.

terbinafine 250 mg tablet, 42

4011D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	30.00	6.40	[a] GenRx Terbinafine [GX]	[a] Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV]
						[a] Tamsil [RW]	[a] Terbinafine GH [GQ]
						[a] Terbinafine Sandoz [SZ]	[a] Tinasil [AF]

▪ EMOLLIENTS AND PROTECTIVES

EMOLLIENTS AND PROTECTIVES

Silicone products

▪ DIMETICONE-350 + GLYCEROL

Restricted benefit
For colostomy and ileostomy use
Restricted benefit
For use by paraplegic and quadriplegic patients
Restricted benefit
For use with surgical appliances

dimeticone-350 15% + glycerol 2% cream, 500 g

4551M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	28.47	6.40	Silic 15 [EO]

dimeticone-350 15% + glycerol 2% cream, 75 g

4556T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	16.40	6.40	Silic 15 [EO]

Soft paraffin and fat products

▪ WOOL ALCOHOLS

wool alcohols 6% ointment, 100 g

4041Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	17.84	6.40	Eucerin [BE]

Carbamide products

▪ UREA

urea 10% cream, 100 g

4042R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	16.11	6.40	Aquacare H.P. [AG]
			..	16.33	6.40	Urederm [KY]
			..	16.61	6.40	Calmurid [OL]

Other emollients and protectives

▪ CARMELLOSE SODIUM + GELATIN + PECTIN

carmellose sodium 16.7% + gelatin 16.7% + pectin 16.7% oromucosal paste, 5 g

4518T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.81	6.40	Orabase [QA]

▪ SKIN EMOLLIENT

SKIN EMOLLIENT Lotion 500 mL, 1

4107E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	20.59	6.40	Alpha Keri Lotion [MT]

SKIN EMOLLIENT Bath oil 500 mL, 1

4122Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	20.59	6.40	Alpha Keri Bath Oil [MT]
			..	22.69	6.40	QV Bath Oil [EO]
			..	22.77	6.40	Hamilton Skin Therapy Oil [KY]

PROTECTIVES AGAINST UV-RADIATION

Protectives against UV-radiation for topical use

▪ SUNSCREENS

SUNSCREENS Cream 75 g, 1

4307Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	21.20	6.40	Sunsense Sensitive SPF 50+ [EO]

SUNSCREENS Lotion (non-alcoholic) 125 mL, 1

4546G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	19.40	6.40	Aquasun Lotion SPF 18 [PF]
			..	21.20	6.40	Sunsense Ultra SPF 50+ [EO]

ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

Anesthetics for topical use

LIGNOCAINE

lignocaine hydrochloride anhydrous 2% oral liquid, 200 mL

4308R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	103.21	6.40	Xylocaine Viscous [QA]

Other antipruritics

TAR + TRIETHANOLAMINE LAURYL SULFATE

Note For patients who have failed to respond to simple moisturising agents.

tar 2.3% + triethanolamine lauryl sulfate 6% solution, 500 mL

4408B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	25.44	6.40	Pinetarsol [EO]

ANTIPSORIATICS

ANTIPSORIATICS FOR TOPICAL USE

Tars

COAL TAR SOLUTION + PHENOL + PRECIPITATED SULFUR

coal tar solution 5% + phenol 0.5% + precipitated sulfur 0.5% gel, 30 g

4505D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	19.44	6.40	Egopsoryl-TA [EO]

ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE

ANTIBIOTICS FOR TOPICAL USE

Other antibiotics for topical use

MUPIROCIN

Restricted benefit

Secondarily infected traumatic skin lesions

mupirocin 2% cream, 15 g

4348W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.51	6.40	Bactroban [GK]

mupirocin 2% ointment, 15 g

4350Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.51	6.40	Bactroban [GK]

CHEMOTHERAPEUTICS FOR TOPICAL USE

Antivirals

PODOPHYLLOTOXIN

Authority required

Ano-genital warts

podophyllotoxin 0.15% cream, 5 g

4390C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	52.83	6.40	Wartec Cream [GK]

Other chemotherapeutics

INGENOL MEBUTATE

Authority required

Solar keratosis

Clinical criteria:

- Patient must require topical drug therapy on the face and scalp as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

ingenol mebutate 0.015% gel, 3 x 470 mg

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2464Q	1	..	..	138.90	6.40	Picato [LO]

▪ INGENOL MEBUTATE

Authority required

Solar (actinic) keratosis

Clinical criteria:

- Patient must require topical drug therapy as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

ingenol mebutate 0.05% gel, 2 x 470 mg

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2468X	1	..	..	138.90	6.40	Picato [LO]

▪ CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS

CORTICOSTEROIDS, PLAIN

Corticosteroids, weak (group I)

▪ HYDROCORTISONE ACETATE

Restricted benefit

Corticosteroid-responsive dermatoses

hydrocortisone acetate 1% ointment, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10831C	‡1	1	..	16.26	6.40	Cortic-DS 1% [QA]

Corticosteroids, potent (group III)

▪ BETAMETHASONE VALERATE

betamethasone (as valerate) 0.1% ointment, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4132L	‡1	2	..	25.01	6.40	Betnovate [QA]

betamethasone (as valerate) 0.1% cream, 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4131K	‡1	2	..	25.01	6.40	Betnovate [QA]

▪ MOMETASONE

Note Application to large areas of skin for longer than four weeks is not recommended.

mometasone furoate 0.1% cream, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4342M	‡1	..	..	34.62	6.40	Elocon [MK]

mometasone furoate 0.1% ointment, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4343N	‡1	..	..	34.62	6.40	Elocon [MK]

▪ ANTISEPTICS AND DISINFECTANTS

ANTISEPTICS AND DISINFECTANTS

Iodine products

▪ POVIDONE-IODINE

povidone-iodine 10% solution, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4411E	‡1	..	..	24.73	6.40	Betadine Antiseptic Liquid [SW]

▪ OTHER DERMATOLOGICAL PREPARATIONS

OTHER DERMATOLOGICAL PREPARATIONS

Medicated shampoos

▪ COAL TAR SOLUTION + TAR + SALICYLIC ACID

coal tar solution 1% + tar 1% + salicylic acid 2% solution, 250 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4447C	‡1	2	..	21.89	6.40	Sebitar [EO]

▪ SALICYLIC ACID + BENZALKONIUM CHLORIDE + ALCOHOL + COAL TAR SOLUTION + POLYOXYETHYLENE ETHERS

SALICYLIC ACID with COAL TAR SOLUTION Scalp cleanser 20 mg-50 mg per mL (2%-5%), 200 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4560B	‡1	2	..	23.23	6.40	Ionil-T [GA]

▪ SELENIUM SULFIDE

selenium sulfide 2.5% shampoo, 125 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4452H	‡1	..	..	17.80	6.40	Selsun [DQ]

▪ TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF COAL TAR

tar 0.3% (300 microgram/mL) + cade oil 0.03% (300 microgram/mL) + coal tar 0.01% (100 microgram/mL) + arachis oil extract of coal tar 0.3% (3 mg/mL) lotion, 300 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4405W	‡1	2	..	26.50	6.40	Polytar [GK]

Wart and anti-corn preparations

▪ SALICYLIC ACID + LACTIC ACID

salicylic acid 16.7% + lactic acid 16.7% application, 15 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4386W	‡1	..	..	21.29	6.40	Duofilm Solution [GK]

Other dermatologicals

▪ DICLOFENAC

Note Maximum quantity of four tubes (original + 3 repeats) in 12 months.

Authority required

Solar (actinic) keratosis

Treatment Phase: Management

Clinical criteria:

- Patient must require topical drug therapy as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

diclofenac sodium 3% gel, 25 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4046Y	‡1	3	..	58.15	6.40	Solaraze 3% Gel [FK]

▪ ICHTHAMMOL

Note For patients who have failed to respond to simple moisturising agents.

ichthammol Cream 5 mg-10 mg-10 mg per g (0.5%-1%-1%), 50 g, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4281H	‡1	2	..	21.25	6.40	Egoderm Cream [EO]

▪ ICHTHAMMOL + ZINC OXIDE

Note For patients who have failed to respond to simple moisturising agents.

ichthammol 1% + zinc oxide 15% ointment, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4280G	‡1	2	..	21.25	6.40	Egoderm Ointment [EO]

▪ IMIQUIMOD

Authority required

Superficial basal cell carcinoma

Treatment Phase: Primary treatment

Clinical criteria:

- The condition must be confirmed by a histological diagnosis, **AND**

- The condition must be one where other standard treatments are inappropriate, **AND**
- The condition must require topical drug therapy.

imiquimod 5% cream, 12 x 250 mg sachets

4559Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	86.62	6.40	[a] Aldiq [QA]	[a] APO-Imiquimod [TX]
			..	88.90	6.40	[a] Aldara [IA]	

▪ IMIQUIMOD

Note Pharmaceutical benefits that have the form imiquimod single use sachets and pharmaceutical benefits that have the form imiquimod multi-use pump are equivalent for the purposes of substitution.

Authority required

Solar keratosis

Clinical criteria:

- Patient must require topical drug therapy on the face and scalp as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

imiquimod 5% cream, 2 x 2 g

10106X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	91.17	6.40	[a] Aldara Pump [IA]

imiquimod 5% cream, 12 x 250 mg sachets

4134N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	86.62	6.40	[a] Aldiq [QA]	[a] APO-Imiquimod [TX]
			..	88.90	6.40	[a] Aldara [IA]	

▪ LIGHT LIQUID PARAFFIN + COCOAMPHODIACETATE DISODIUM

light liquid paraffin 3.5% + cocoamphodiacetate disodium 3% lotion, 500 mL

4549K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	23.54	6.40	Hamilton Skin Therapy Wash [KY]

▪ PANTHENOL

Note To be used in conjunction with the scalp cleanser salicylic acid with coal tar solution and pine tar (code 4447C).

panthenol conditioner, 200 g

4510J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	17.90	6.40	SebiRinse [EO]

▪ ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN + PURIFIED TALC

zinc oxide 25% + maize starch 55.85% + chlorphenesin 1% + purified talc 18.07% dusting powder, 100 g

4497Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	16.16	6.40	Z.S.C. [RW]

▪ GENITO URINARY SYSTEM AND SEX HORMONES

▪ GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS

ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS

Antibiotics

▪ NYSTATIN

nystatin 20 000 units/g vaginal cream, 75 g

4013F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	17.50	6.40	Nilstat [QA]

Imidazole derivatives

▪ CLOTRIMAZOLE

clotrimazole 2% vaginal cream, 20 g

4017K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	..	..	18.62	6.40	APO-Clotrimazole 3 Day Cream [TX]	Clonea 3 Day Cream [AF]

clotrimazole 1% vaginal cream, 35 g

4016J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	..	..	17.41	6.40	[a] Clonea 6 Day Cream [AF]	[a] Pharmacy Action FemCream [GQ]
			..	18.62	6.40	[a] APO-Clotrimazole 6 Day Cream [TX]	

▪ OTHER GYNECOLOGICALS

OTHER GYNECOLOGICALS

▪ ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID

acetic acid 0.94% + hydroxyquinoline sulfate 0.025% + ricinoleic acid 0.75% vaginal gel, 100 g

4434J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	34.12	6.40	Aci-Jel [CU]

▪ UROLOGICALS

UROLOGICALS

Drugs used in erectile dysfunction

▪ ALPROSTADIL

Authority required

Erectile dysfunction

Clinical criteria:

- The condition must be vasculogenic; OR
- The condition must be psychogenic; OR
- The condition must be neurogenic, **AND**
- Patient must have a specific accepted war-caused or service-related disability.

Population criteria:

- Patient must be male.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats.

alprostadil 20 microgram injection [2] (&) inert substance diluent [2 x 0.6 mL syringes], 1 pack

4580C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	3	..	*125.98	6.40	Caverject Impulse [PF]

alprostadil 10 microgram injection [2] (&) inert substance diluent [2 x 0.6 mL syringes], 1 pack

4579B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	3	..	*101.14	6.40	Caverject Impulse [PF]

▪ SILDENAFIL

Authority required

Erectile dysfunction

Clinical criteria:

- The condition must be vasculogenic; OR
- The condition must be psychogenic; OR
- The condition must be neurogenic, **AND**
- Patient must have a specific accepted war-caused or service-related disability.

Population criteria:

- Patient must be male.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats.

sildenafil 25 mg tablet, 4

4584G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	55.04	6.40	[a] Sildenafil Actavis [EA] [a] Vedafil [AF]	[a] Vasafil 25 [RW]
			..	55.05	6.40	[a] APO-Sildenafil [TX]	
			..	63.42	6.40	[a] Viagra [PF]	

sildenafil 50 mg tablet, 4

4585H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	67.04	6.40	[a] APO-Sildenafil [TX] [a] Vasafil 50 [RW]	[a] Sildenafil Actavis [EA] [a] Vedafil [AF]
			..	77.70	6.40	[a] Viagra [PF]	

sildenafil 100 mg tablet, 4

4586J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	71.61	6.40	[a] APO-Sildenafil [TX] [a] Sildenafil Actavis [EA] [a] Terry White Chemists Sildenafil [TW] [a] Vedafil [AF]	[a] Chem mart Sildenafil [CH] [a] Sildenafil generichealth [GQ] [a] Vasafil 100 [RW]
			..	83.14	6.40	[a] Silaran [RA]	[a] Viagra [PF]

▪ TADALAFIL

Authority required

Erectile dysfunction

Clinical criteria:

- The condition must be vasculogenic; OR
- The condition must be psychogenic; OR
- The condition must be neurogenic, **AND**
- Patient must have a specific accepted war-caused or service-related disability.

Population criteria:

- Patient must be male.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats.

tadalafil 20 mg tablet, 4

4597Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	103.85	6.40	Cialis [LY]

tadalafil 10 mg tablet, 4

4596X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	103.85	6.40	Cialis [LY]

▪ VARDENAFIL

Authority required

Erectile dysfunction

Clinical criteria:

- The condition must be vasculogenic; OR
- The condition must be psychogenic; OR
- The condition must be neurogenic, **AND**
- Patient must have a specific accepted war-caused or service-related disability.

Population criteria:

- Patient must be male.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats.

vardenafil 20 mg tablet, 4

4302K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	81.18	6.40	Levitra [BN]

vardenafil 10 mg tablet, 4

4290T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	5	..	71.43	6.40	Levitra [BN]

Other urologicals

▪ BICARBONATE + CITRIC ACID + TARTARIC ACID

Restricted benefit

Urinary symptoms

Clinical criteria:

- The treatment must be for when antibiotic or other therapy alone is inappropriate.

sodium bicarbonate 1.76 g + sodium citrate 630 mg + citric acid 720 mg + tartaric acid 890 mg powder for oral liquid, 28 x 4 g sachets

4049D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	4	..	17.29	6.40	Uracol [EA]	Ural Sachets [QA]

DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY

Alpha-adrenoreceptor antagonists

▪ ALFUZOSIN

Authority required

Benign prostatic hyperplasia

RPBS

Clinical criteria:

- Patient must be one in whom surgery is inappropriate; OR
- Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

alfuzosin hydrochloride 10 mg modified release tablet, 30

4277D

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	62.85	6.40	Xatral SR [SW]

▪ DUTASTERIDE + TAMSULOSIN

Authority required

Benign prostatic hyperplasia

Clinical criteria:

- Patient must be one in whom surgery is inappropriate; OR
- Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram modified release capsule, 30

10102Q

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	31.97	6.40	Duodart 500ug/400ug [GK]

▪ TAMSULOSIN

Authority required

Benign prostatic hyperplasia

Clinical criteria:

- Patient must be one in whom surgery is inappropriate; OR
- Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

tamsulosin hydrochloride 400 microgram modified release tablet, 30

4070F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	62.85	6.40	Flomaxtra [LS]	Tamsulosin Sandoz SR [SZ]

Testosterone-5-alpha reductase inhibitors

▪ DUTASTERIDE

Authority required

Benign prostatic hyperplasia

Clinical criteria:

- Patient must be one in whom surgery is inappropriate; OR
- Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

dutasteride 500 microgram capsule, 30

10095H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
1	5	..	27.76	6.40	Avodart [GK]

▪ FINASTERIDE

Authority required

Benign prostatic hyperplasia

Clinical criteria:

- Patient must be one in whom surgery is inappropriate; OR
- Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

finasteride 5 mg tablet, 30

4233T

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	75.88	6.40	[a] Auro-Finasteride [DO]	[a] Finasteride AN [EA]
					[a] Finasteride GH 5 [GQ]	[a] Finide [AL]
		..	93.73	6.40	[a] Finnacar [RW]	
		..	98.08	6.40	[a] APO-Finasteride [TX]	[a] Finasta [SZ]
					[a] Finasteride Alphapharm [AF]	[a] Finasteride-GA 5 [GN]
					[a] Pharmacor Finasteride 5 [CR]	[a] Proscar [MK]

finasteride 5 mg tablet, 28

4303L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	88.22	6.40	[a] Finpro [RZ]	[a] Pharmacy Choice Finasteride [RI]

ANTIINFECTIVES FOR SYSTEMIC USE

ANTIBACTERIALS FOR SYSTEMIC USE

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

AZITHROMYCIN

Restricted benefit

Upper and lower respiratory tract infections

azithromycin 500 mg tablet, 3

4115N

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	..	..	32.91	6.40	Zedd 500 [RW]	
					[a] APO-Azithromycin [TX]	[a] Azithromycin-GA [EA]
					[a] Azithromycin Mylan [AF]	[a] Azithromycin Sandoz [SZ]
					[a] Chem mart Azithromycin [CH]	[a] Terry White Chemists Azithromycin [TW]
					[a] Zithromax [PF]	[a] Zitrocin [GN]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ANTINEOPLASTIC AGENTS

ANTIMETABOLITES

Pyrimidine analogues

FLUOROURACIL

fluorouracil 5% cream, 20 g

4222F

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
‡1	..	..	65.28	6.40	[a] APOC-5FU [TX]	[a] Efudix [IA]

IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Tumor necrosis factor alpha (TNF-) inhibitors

INFLIXIMAB

Note Any queries concerning the arrangements to prescribe infliximab may be directed to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) on 1800 552 580.

Written applications for authority to prescribe infliximab should be forwarded to:
Reply Paid 9998
Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC)
Department of Veterans' Affairs
GPO Box 9998
BRISBANE QLD 4001

Authority required

Initial treatment, in combination with methotrexate, of specific accepted war-caused or service-related disability of refractory rheumatoid arthritis. Initial treatment may be prescribed by rheumatologists or consultant physicians for the reduction of signs and symptoms and prevention of structural joint damage in adult patients with active rheumatoid arthritis who satisfy all of the following criteria:

(1) (a) Proven raised erythrocyte sedimentation rate (ESR) and/or C-reactive protein (CRP); and

(1) (b) Proven erosive rheumatoid arthritis without end-stage disease;

(2) Failure of an adequate trial of methotrexate and 2 other disease modifying anti-rheumatic drugs (such as sulfasalazine, hydroxychloroquine, leflunomide or cyclosporin) — unless these drugs were contraindicated or intolerance had developed;

(3) No history of active tuberculosis requiring treatment in the last 3 years;

(4) No history of opportunistic infection in the last 2 months;

(5) Female patients of child-bearing age are not pregnant, not breast-feeding, and are using an effective form of contraception.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Infliximab (Remicade) RPBS Authority Application - Supporting Information form (contact the VAPAC on 1800 552 580 for a copy of the form)

Authority required

Continuing treatment, in combination with methotrexate, of specific accepted war-caused or service-related disability of refractory rheumatoid arthritis. Continuing treatment may be prescribed by rheumatologists or consultant physicians, following initial therapy of 3 doses, in patients who satisfy the following criteria:

(1) There is improvement in ESR and/or CRP; and

(2) An ACR20 (American College of Rheumatology) response is achieved by 14 weeks after the commencement of therapy.
Applications for authorisation must be in writing and must include:
(1) a completed authority prescription form; and
(2) a completed Infliximab (Remicade) RPBS Authority Application - Supporting Information form (contact the VAPAC on 1800 552 580 for a copy of the form)

infliximab 100 mg injection, 1 vial

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4284L	1	2	..	569.47	6.40	Remicade [JC]

MUSCULO-SKELETAL SYSTEM

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

Preparations with salicylic acid derivatives

EUCALYPTUS OIL + MENTHOL + METHYL SALICYLATE

eucalyptus oil 10% + menthol 4% + methyl salicylate 25% cream, 100 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4022Q	‡1	1	..	17.70	6.40	Gold Cross [BI]

METHYL SALICYLATE

methyl salicylate 50% ointment, 100 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4023R	‡1	1	..	16.09	6.40	Gold Cross [BI]

methyl salicylate 25% liniment, 100 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4026X	‡1	1	..	14.15	6.40	Gold Cross [BI]

DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

RISEDRONATE

Authority required

Preservation of bone mineral density

Clinical criteria:

- Patient must be on long-term glucocorticoid therapy, **AND**
- Patient must be undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day, **AND**
- Patient must be osteopenic (bone mineral density t-score of less than -1.0).

Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more.

risedronate sodium 35 mg tablet, 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
4444X	1	5	..	35.10	6.40	[a] Acris Once-a-Week [AF] [a] Risedronate AN [EA] [a] Risedronate Sandoz [SZ]	[a] APO-Risedronate [TX] [a] Risedronate-GA [GN] [a] Risedro once a week [RW]

RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2191H	1	5	..	35.10	6.40	Actonel EC [UA]

risedronate sodium 5 mg tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4443W	1	5	..	35.10	6.40	Actonel [UA]

Bisphosphonates, combinations

ALENDRONATE + COLECALCIFEROL

Authority required

Preservation of bone mineral density

Clinical criteria:

- Patient must be on long-term glucocorticoid therapy, **AND**

- Patient must be undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day, **AND**
- Patient must be osteopenic (bone mineral density t-score of less than -1.0).

Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more.

alendronate 70 mg + colecalciferol 140 microgram (5600 units) tablet, 4

2224C

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	17.94	6.40	[a] Alendronate plus D3-DRLA [RZ] [a] Chem mart Alendronate Plus D3 70 mg/140 mcg [CH] [a] Terry White Chemists Alendronate Plus D3 70 mg/140 mcg [TW]	[a] APO-Alendronate Plus D3 70 mg/140 mcg [TX] [a] FonatPlus [AF]
		..	21.94	6.40	[a] Fosamax Plus 70 mg/140 mcg [MK]	

alendronate 70 mg + colecalciferol 70 microgram tablet, 4

2194L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	17.94	6.40	[a] Alendronate plus D3-DRLA [RZ] [a] Chem mart Alendronate Plus D3 70 mg/70 mcg [CH] [a] Terry White Chemists Alendronate Plus D3 70 mg/70 mcg [TW]	[a] APO-Alendronate Plus D3 70 mg/70 mcg [TX] [a] FonatPlus [AF]
		..	21.94	6.40	[a] Fosamax Plus [MK]	

▪ ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE

Authority required

Preservation of bone mineral density

Clinical criteria:

- Patient must be on long-term glucocorticoid therapy, **AND**
- Patient must be undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day, **AND**
- Patient must be osteopenic (bone mineral density t-score of less than -1.0).

Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more.

alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack

2273P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	22.83	6.40	[a] APO-Alendronate Plus D3 and Calcium [TX]
		..	24.71	6.40	[a] Fosamax Plus D-Cal [MK]

▪ RISEDRONATE (&) CALCIUM CARBONATE

Authority required

Preservation of bone mineral density

Clinical criteria:

- Patient must be on long-term glucocorticoid therapy, **AND**
- Patient must be undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day, **AND**
- Patient must be osteopenic (bone mineral density t-score of less than -1.0).

Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more.

RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

2220W

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	35.10	6.40	Actonel EC Combi [UA]

risedronate sodium 35 mg tablet [4] (&) calcium (as carbonate) 500 mg tablet [24], 28

4059P

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	5	..	35.10	6.40	Acris Combi [AF]

▪ RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL

Authority required

Preservation of bone mineral density

Clinical criteria:

- Patient must be on long-term glucocorticoid therapy, **AND**

RPBS

- Patient must be undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day, **AND**
- Patient must be osteopenic (bone mineral density t-score of less than -1.0).

Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more.

RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2254P	‡1	5	..	35.10	6.40	Actonel EC Combi D [UA]

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

MORPHINE

Caution The risk of drug dependence is high.

Note Authorities for increased maximum quantities and/or repeats will be granted only for:
(i) chronic severe disabling pain associated with proven malignant neoplasia; or
(ii) chronic severe disabling pain where treatment has been initiated by a specialist with appropriate expertise in pain management.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

- The condition must be unresponsive to non-opioid analgesics.

morphine sulfate 200 mg modified release tablet, 28

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4349X	1	..	..	116.58	6.40	MS Contin [MF]

Opioids in combination with non-opioid analgesics

ASPIRIN + CODEINE

aspirin 300 mg + codeine phosphate hemihydrate 8 mg dispersible tablet, 40

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4286N	1	2	..	17.84	6.40	Aspalgin 40 [QA]

PARACETAMOL + CODEINE

paracetamol 500 mg + codeine phosphate hemihydrate 8 mg tablet, 40

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4275B	1	2	..	14.80	6.40	Panamax Co. 40 [SW]

OTHER ANALGESICS AND ANTIPYRETICS

Anilides

PARACETAMOL

paracetamol 240 mg/5 mL oral liquid, 200 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10599W	‡1	2	..	14.79	6.40	Panamax 240 Elixir [SW]

paracetamol 500 mg tablet, 100

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
10582Y	1	1	..	12.74	6.40	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

PARACETAMOL

Restricted benefit

Persistent pain

Clinical criteria:

- The condition must be associated with osteoarthritis.

RPBS

paracetamol 665 mg modified release tablet, 96

10598T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	5	..	*18.55	6.40	Osteomol 665 Paracetamol [CR]

▪ PARACETAMOL

Restricted benefit

Chronic arthropathies

paracetamol 500 mg tablet, 100

10585D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	4	..	*16.03	6.40	[a] APO-Paracetamol [TX] [a] Generic Health Pty Ltd [GQ] [a] Paracetamol (Sandoz) [SZ] [a] Parapane [AF]	[a] Febridol [EA] [a] Panamax [SW] [a] Paralgin [OW]

Other analgesics and antipyretics

▪ GABAPENTIN

Authority required

Refractory neuropathic pain

Clinical criteria:

- The condition must be unable to be controlled by other drugs.

gabapentin 100 mg capsule, 100

4591P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	15.13	6.40	[a] APO-Gabapentin [TX] [a] Neurontin [PF]	[a] Gabapentin Aspen 100 [RW] [a] Nupentin 100 [AF]

gabapentin 300 mg capsule, 100

4592Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	24.59	6.40	[a] Gabapentin 300 [CR] [a] Gabapentin GH [GQ] [a] GenRx Gabapentin [GX] [a] Nupentin 300 [AF]	[a] Gabapentin Aspen 300 [RW] [a] Gantin [EA] [a] Neurontin [PF]

gabapentin 600 mg tablet, 100

4594T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	40.31	6.40	[a] Gabapentin AN [EA] [a] GenRx Gabapentin [GX] [a] Nupentin Tabs [AF]	[a] Gabapentin Aspen 600 [RW] [a] Neurontin [PF]

gabapentin 400 mg capsule, 100

4593R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	29.50	6.40	[a] Gabapentin 400 [CR] [a] Gabapentin GH [GQ] [a] GenRx Gabapentin [GX] [a] Nupentin 400 [AF]	[a] Gabapentin Aspen 400 [RW] [a] Gantin [EA] [a] Neurontin [PF]

gabapentin 800 mg tablet, 100

4595W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	50.06	6.40	[a] Gabapentin AN [EA] [a] Gantin [ED] [a] Neurontin [PF]	[a] Gabapentin Aspen 800 [RW] [a] GenRx Gabapentin [GX] [a] Nupentin Tabs [AF]

▪ PSYCHOLEPTICS

ANXIOLYTICS

Benzodiazepine derivatives

▪ BROMAZEPAM

Note This drug should not be used as the first line of treatment.

Note Other PBS-listed benzodiazepines should have been adequately tried and found to be ineffective or inappropriate.

Note Authorities for increased quantities and/or repeats may be granted to patients with terminal disease, and other patients who have been shown to be dependent on this item by an unsuccessful attempt at gradual withdrawal.

Authority required

Terminal disease

Clinical criteria:

- The treatment must be for the short-term, **AND**

- Patient must be receiving palliative care.

Authority required

Refractory phobic or anxiety states

Clinical criteria:

- The treatment must be for the short-term.

bromazepam 6 mg tablet, 30

4151L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*36.89	6.40	Lexotan [RO]

bromazepam 3 mg tablet, 30

4150K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*31.15	6.40	Lexotan [RO]

Azaspirodecanedione derivatives

▪ BUSPIRONE

Authority required

Anxiety

Clinical criteria:

- The treatment must be for the short-term.

buspirone hydrochloride 5 mg tablet, 50

4144D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	38.54	6.40	Buspar [QA]

buspirone hydrochloride 10 mg tablet, 50

4145E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	55.01	6.40	Buspar [QA]

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

▪ FLUNITRAZEPAM

Note This drug should not be used as the first line of treatment.

Note Other PBS-listed benzodiazepines should have been adequately tried and found to be ineffective or inappropriate.

Note Authorities for increased quantities and/or repeats may be granted to patients with terminal disease, and other patients who have been shown to be dependent on this item by an unsuccessful attempt at gradual withdrawal.

Authority required

Terminal disease

Clinical criteria:

- The treatment must be for the short-term, **AND**
- Patient must be receiving palliative care.

Authority required

Refractory phobic or anxiety states

Clinical criteria:

- The treatment must be for the short-term.

flunitrazepam 1 mg tablet, 30

4216X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	19.10	6.40	Hypnodorm [AF]

Benzodiazepine related drugs

▪ ZOPICLONE

Restricted benefit

Insomnia

Clinical criteria:

- The treatment must be for the short-term.

zopiclone 7.5 mg tablet, 30

4522B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	24.43	6.40	[a] APO-Zopiclone [TX] [a] Imrest [AF] [a] Zopiclone GH [GQ]	[a] Chem mart Zopiclone [CH] [a] Terry White Chemists Zopiclone [TW]
			..	27.17	6.40	[a] Imovane [SW]	

RPBS

OTHER NERVOUS SYSTEM DRUGS

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in nicotine dependence

NICOTINE

Note Studies have shown that successful therapy with this drug is enhanced by patient participation in a support and counselling program.

Authority required
Nicotine dependence
Clinical criteria:
- Patient must have indicated they are ready to cease smoking, **AND**
- Patient must have entered a comprehensive support and counselling program.

nicotine 7 mg/24 hours patch, 7

4571N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*51.57	6.40	QuitX [AF]

nicotine 14 mg/24 hours patch, 7

4572P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*54.73	6.40	QuitX [AF]
			..	*67.75	6.40	Nicabate CQ 14 [GC]

nicotine 5 mg/16 hours patch, 7

4576W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*50.97	6.40	Nicorette Patch [JT]

nicotine 10 mg/16 hours patch, 7

4577X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*54.95	6.40	Nicorette Patch [JT]

nicotine 15 mg/16 hours patch, 7

4578Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	2	..	*59.77	6.40	Nicorette Patch [JT]

nicotine 21 mg/24 hours patch, 7

4573Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	2	..	*57.69	6.40	QuitX [AF]
			..	*67.75	6.40	Nicabate CQ 21 [GC]

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

ANTHELMINTICS

ANTINEMATODAL AGENTS

Benzimidazole derivatives

MEBENDAZOLE

mebendazole 100 mg tablet, 6

4325P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	17.29	6.40	Pharmacy Action Worm Treatment [GQ]

RESPIRATORY SYSTEM

NASAL PREPARATIONS

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE

Sympathomimetics, plain

OXYMETAZOLINE

oxymetazoline hydrochloride 0.05% nasal spray, 18 mL

4379L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.08	6.40	Logicin Rapid Relief [QA]

oxymetazoline hydrochloride 0.05% nasal spray, 15 mL

4378K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.42	6.40	Drixine [BN]

Antiallergic agents, excl. corticosteroids

▪ CROMOGLYCATE

sodium cromoglycate 2% nasal spray, 26 mL

4468E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	25.43	6.40	Rynacrom [SW]

▪ LEVOCABASTINE

levocabastine 0.05% nasal spray, 100 actuations

4311X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	21.37	6.40	Livostin [JT]

Corticosteroids

▪ BUDESONIDE

Restricted benefit
Severe intractable rhinitis

budesonide 64 microgram/actuation nasal spray, 120 actuations

4092J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	41.68	6.40	Budamax Aqueous [PM]

Other nasal preparations

▪ IPRATROPIUM

Restricted benefit
Severe intractable rhinorrhoea
Clinical criteria:

- The condition must be associated with perennial rhinitis, **AND**
- The condition must be unresponsive to insufflated nasal steroids.

ipratropium bromide monohydrate 22 microgram/actuation nasal spray, 180 actuations

4089F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	26.48	6.40	Atrovent Nasal Aqueous [VZ]

ipratropium bromide monohydrate 44 microgram/actuation nasal spray, 180 actuations

4090G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	5	..	32.63	6.40	Atrovent Nasal Forte [VZ]

NASAL DECONGESTANTS FOR SYSTEMIC USE

Sympathomimetics

▪ PSEUDOEPHEDRINE

pseudoephedrine hydrochloride 60 mg tablet, 12

4029C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	14.44	6.40	[a] Pharmacy Action Sinus & Nasal Decongestant Relief [GQ]
			..	15.09	6.40	[a] Logicin Sinus [QA]

▪ COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Expectorants

▪ AMMONIUM + SENEGA ROOT

ammonium bicarbonate 25 mg/mL + senega root 25 mg/mL oral liquid, 200 mL

4074K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	4	..	13.49	6.40	Gold Cross [BI]

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS

Opium alkaloids and derivatives

▪ PHOLCODINE

pholcodine 1 mg/mL oral liquid, 100 mL

4071G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	13.35	6.40	Gold Cross [BI]
			..	18.21	6.40	Duro-Tuss [IA]

▪ ANTIHISTAMINES FOR SYSTEMIC USE

ANTIHISTAMINES FOR SYSTEMIC USE

Piperazine derivatives

▪ CETIRIZINE

cetirizine hydrochloride 10 mg tablet, 30

4175R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	28.06	6.40	[a] Pharmacy Action Cetrelief [GQ]
			..	31.29	6.40	[a] Alzene [AF]
			..	34.09	6.40	Zilarex [SZ]
			..	39.81	6.40	[a] Zyrtec [JT]

Other antihistamines for systemic use

▪ FEXOFENADINE

fexofenadine hydrochloride 120 mg tablet, 30

4238C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	27.88	6.40	[a] Pharmacy Action Fexorelief 120 [GQ]
			..	31.09	6.40	[a] Xergic [AF]
			..	35.69	6.40	[a] Fexal [SZ]
			..	47.30	6.40	[a] Telfast 120 [SW]

fexofenadine hydrochloride 60 mg tablet, 20

4237B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	..	..	*55.15	6.40	Telfast [SW]

▪ LORATADINE

loratadine 10 mg tablet, 30

4313B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	30.49	6.40	[a] Pharmacy Action Lorastyne [GQ]
			..	34.19	6.40	[a] Allereze [AF]
			..	43.82	6.40	[a] Lorano [SZ]
			..	46.09	6.40	[a] Claratyne [BN]

▪ SENSORY ORGANS

▪ OPHTHALMOLOGICALS

DECONGESTANTS AND ANTIALLERGICS

Sympathomimetics used as decongestants

▪ NAPHAZOLINE

naphazoline hydrochloride 0.1% eye drops, 15 mL

4035J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	18.63	6.40	Albalon Liquifilm [AG]

▪ NAPHAZOLINE + ANTAZOLINE

naphazoline hydrochloride 0.05% + antazoline phosphate 0.5% eye drops, 15 mL

4032F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	18.38	6.40	Albalon-A [AG]

Other antiallergics

▪ LEVOCABASTINE

levocabastine 0.05% eye drops, 4 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4310W	‡1	1	..	21.37	6.40	Livostin [JT]

▪ OTOLOGICALS

OTHER OTOLOGICALS

Indifferent preparations

▪ CARBAMIDE PEROXIDE

carbamide peroxide 6.5% ear drops, 12 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4176T	‡1	..	..	20.57	6.40	Ear Clear for Ear Wax Removal [KY]

▪ DICHLOROBENZENE WITH CHLORBUTOL AND ARACHIS OIL

DICHLOROBENZENE with CHLORBUTOL and ARACHIS OIL Ear drops, ortho-dichlorobenzene 140 mg per mL, para-dichlorobenzene 20 mg per mL, chlorbutol 50 mg per mL, arachis oil 573 mg per mL, 10 mL, 1

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4180B	‡1	..	..	17.75	6.40	Cerumol [UN]

▪ DOCUSATE

docusate sodium 0.5% ear drops, 10 mL

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4199B	‡1	..	..	18.09	6.40	Waxsol [HM]

▪ VARIOUS

▪ ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Drugs for treatment of hyperkalemia and hyperphosphatemia

▪ SODIUM POLYSTYRENE SULFONATE

sodium polystyrene sulfonate 999.3 mg/g powder, 454 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4470G	‡1	2	..	69.91	6.40	Resonium-A [SW]

▪ GENERAL NUTRIENTS

OTHER NUTRIENTS

Other combinations of nutrients

▪ PROTEIN FORMULA WITH ARGININE, VITAMIN C AND E

Restricted benefit

Stage 2 and above pressure injury

Clinical criteria:

- The treatment must be for special medical purposes to support healing of pressure injuries.

protein formula with arginine, vitamin C and E powder for oral liquid, 14 x 9.2 g sachets

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10850C	4	5	..	*158.63	6.40	Arginaid [NT]

▪ PROTEIN FORMULA WITH ARGININE, VITAMIN C, E AND ZINC

Restricted benefit

Stage 2 and above pressure injury

Clinical criteria:

- The treatment must be for special medical purposes to support healing of pressure injuries.

protein formula with arginine, vitamin C, E and zinc oral liquid, 27 x 237 mL cartons

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10841N	2	5	..	*263.19	6.40	Arginaid Extra [NT]

ALL OTHER NON-THERAPEUTIC PRODUCTS

ALL OTHER NON-THERAPEUTIC PRODUCTS

LUBRICATING AGENT

lubricating agent jelly, 100 g

4306P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	14.32	6.40	Lubri-Gel [PP]

Other non-therapeutic auxiliary products

BANDAGE ABSORBENT WOOL

bandage absorbent wool 10 cm x 3 m bandage, 1

4653X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	23.18	6.40	Surepress 650948 [CC]

BANDAGE CALICO

bandage calico large triangular bandage, 1

4717G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	17.10	6.40	Handy 36361414 [BV]

BANDAGE COMPRESSION

Note Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

BANDAGE-COMPRESSION Bandage, short stretch, 8 cm x 2.6 m, 1

4654Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*76.90	6.40	Comprilan 01027-00 [BV]

bandage compression 10 cm x 3 m high stretch bandage, 1

4748X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*71.55	6.40	Surepress 650947 [CC]
			..	*149.85	6.40	Tensopress 71723-00 [BV]

BANDAGE COMPRESSION

Note Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

bandage compression four layer bandage, 1

4598B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*169.75	6.40	Profore Lite 66050415 [SN]

bandage compression four layer bandage, 1

4658E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*253.40	6.40	Profore 66050016 [SN]

BANDAGE COMPRESSION

Note Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage compression 10 cm x 3.5 m high stretch bandage, 1

4657D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*76.70	6.40	Setopress 3505 [MH]

BANDAGE COMPRESSION

Note Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

Note Bandage can be left in situ for up to 7 days as per manufacturer's instructions.

Restricted benefit

Venous ulcer

Treatment Phase: Initial treatment

Restricted benefit
Venous ulcer
Treatment Phase: Continuing treatment

bandage compression two layer bandage, 1

4050E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	42.85	6.40	Coban 2 [MM]

▪ BANDAGE RETENTION COHESIVE HEAVY

bandage retention cohesive heavy 10 cm x 1.3 m bandage, 1

4813H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*23.83	6.40	Peg 7423 [MM]

bandage retention cohesive heavy 15 cm x 1.3 m bandage, 1

4814J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*30.01	6.40	Peg 7425 [MM]

bandage retention cohesive heavy 7.5 cm x 1.3 m bandage, 1

4812G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*20.55	6.40	Peg 7422 [MM]

bandage retention cohesive heavy 5 cm x 1.3 m bandage, 1

4811F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*17.69	6.40	Peg 7420 [MM]

bandage retention cohesive heavy 10 cm x 2 m bandage, 1

4660G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*22.35	6.40	Coban 1584 [MM]

▪ BANDAGE RETENTION COHESIVE LIGHT

bandage retention cohesive light 10 cm x 2 m bandage, 1

4662J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*33.47	6.40	Handygauze Cohesive 8635 [BV]

bandage retention cohesive light 6 cm x 2 m bandage, 1

4719J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*19.61	6.40	Handygauze Cohesive 8633 [BV]

bandage retention cohesive light 2.5 cm x 2 m bandage, 2

4718H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	17.23	6.40	Handygauze Cohesive 8631 [BV]

▪ BANDAGE RETENTION COTTON CREPE

bandage retention cotton crepe 10 cm x 2.3 m bandage, 1

4729X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*27.57	6.40	Telfa 8254F [KE]
			..	*33.01	6.40	Tensocrepe 36301001 [BV]

bandage retention cotton crepe 5 cm x 2.3 m bandage, 1

4727T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*20.65	6.40	Telfa 8252F [KE]
			..	*23.31	6.40	Tensocrepe 36300501 [BV]

bandage retention cotton crepe 7.5 cm x 2.3 m bandage, 1

4728W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*24.83	6.40	Telfa 8253F [KE]
			..	*27.87	6.40	Tensocrepe 36307501 [BV]

▪ BANDAGE TUBULAR

bandage tubular size E (35 cm to 45 cm) straight bandage, 1

4665M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.89	6.40	Elastoplast 2227 [BE]

bandage tubular size C (15 cm to 25 cm) straight bandage, 1

4663K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.89	6.40	Elastoplast 2225 [BE]

bandage tubular size D (25 cm to 43 cm) straight bandage, 1

4664L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.89	6.40	Elastoplast 2226 [BE]

▪ BANDAGE TUBULAR

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular 8.75 cm x 1 m bandage, 1

4858Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.53	6.40	Tubigrip E 1547 [MH]

bandage tubular 10 cm x 1 m bandage, 1

4859R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.53	6.40	Tubigrip F 1548 [MH]

bandage tubular 6.75 cm x 1 m bandage, 1

4856N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.53	6.40	Tubigrip C 1545 [MH]

bandage tubular 6.25 cm x 1 m bandage, 1

4855M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.53	6.40	Tubigrip B 1520 [MH]

bandage tubular 7.5 cm x 1 m bandage, 1

4857P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.53	6.40	Tubigrip D 1546 [MH]

▪ BANDAGE TUBULAR FINGER

BANDAGE-TUBULAR (FINGER) Complete pack including applicator, 1

4798M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.96	6.40	Tubegauz 0501633 [SS]

▪ BANDAGE TUBULAR LIGHT WEIGHT

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular light weight 10 m small limb size bandage, 1

4671W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	25.30	6.40	Tubifast 2434 [MH]

bandage tubular light weight 10 m medium limb size bandage, 1

4672X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	28.74	6.40	Tubifast 2436 [MH]

bandage tubular light weight 10 m large limb size bandage, 1

4673Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	29.97	6.40	Tubifast 2438 [MH]

▪ BANDAGE TUBULAR LONG STOCKING

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular long stocking XX/large size bandage, 1

4675C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*37.81	6.40	Tubigrip 1486 [MH]

bandage tubular long stocking large size bandage, 1

4799N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*37.79	6.40	Tubigrip 1484 [MH]

bandage tubular long stocking small size bandage, 1

4674B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*37.79	6.40	Tubigrip 1482 [MH]

bandage tubular long stocking medium size bandage, 1

4797L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*37.79	6.40	Tubigrip 1483 [MH]

▪ BANDAGE TUBULAR SHORT STOCKING

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular short stocking small B/C size bandage, 1

4661H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*27.57	6.40	Tubigrip 1479 [MH]

bandage tubular short stocking medium C/D size bandage, 1

4815K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*27.57	6.40	Tubigrip 1480 [MH]

bandage tubular short stocking large D/E size bandage, 1

4816L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*27.57	6.40	Tubigrip 1481 [MH]

▪ BANDAGE ZINC PASTE

Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

bandage zinc paste 10 cm x 9.1 m bandage, 1

4670T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	3	..	*30.53	6.40	Flexidress 650941 [CC]

▪ BANDAGE ZINC PASTE

Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage zinc paste 7.5 cm x 6 m bandage, 1

4669R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	3	..	*31.29	6.40	Steripaste 3610 [MH]

▪ BANDAGE ZINC PASTE

Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

bandage zinc paste 7.5 cm x 6 m bandage, 1

4750B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	3	..	*86.29	6.40	Viscopaste 4948 [SN]

bandage zinc paste 80 cm (stockings) bandage, 4

4760M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	3	..	98.90	6.40	ZipZoc 66000747 [SN]

▪ BETAINE + POLYAMINOPROPYL BIGUANIDE

betaine 0.1% + polyaminopropyl biguanide 0.1% solution, 6 x 40 mL ampoules

2525X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	28.70	6.40	Prontosan Wound Irrigation Solution [BR]

▪ CADEXOMER-IODINE

Note Suitable for yellow sloughy infected and malodorous wounds.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

cadexomer-iodine 50% ointment, 4 x 10 g

4932N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	121.99	6.40	Iodosorb Ointment 66051240 [SN]

DRESSING with CADEXOMER IODINE Sheets 5 g (6 cm x 4 cm), 5, 1

4935R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	115.50	6.40	Iodosorb 66051330 [SN]

DRESSING with CADEXOMER IODINE Sheets 17 g (10 cm x 8 cm), 2, 1

4937W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	173.84	6.40	Iodosorb 66051360 [SN]

cadexomer-iodine 8 cm x 6 cm dressing, 3 x 10 g sheet

4936T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	165.18	6.40	Iodosorb 66051340 [SN]

cadexomer-iodine 50% ointment, 2 x 20 g

4933P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	120.88	6.40	Iodosorb Ointment 66051230 [SN]

cadexomer-iodine 3 g sterile dusting powder, 7 sachets

4931M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	77.25	6.40	Iodosorb Powder 66051070 [SN]

▪ DRESSING ACTIVATED CHARCOAL MALODOROUS WOUND

dressing activated charcoal malodorous wound 10.5 cm x 10.5 cm dressing, 1

4681J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	..	..	*96.95	6.40	Actisorb Plus MAP105 [KI]

dressing activated charcoal malodorous wound 15 cm x 20 cm dressing, 5

4743P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	86.95	6.40	CarboFLEX 403204 [CC]

dressing activated charcoal malodorous wound 10 cm x 10 cm dressing, 10

4742N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	77.05	6.40	CarboFLEX 403202 [CC]

▪ DRESSING ALGINATE CAVITY WOUND

Note This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 5

1905G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	..	..	*110.03	6.40	Kaltostat 168117 [CC]

DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 1

4832H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10	..	..	*104.45	6.40	Sorbsan 1411 [UM]

▪ DRESSING ALGINATE CAVITY WOUND

Note This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing alginate cavity wound 2 g (40 cm) rope, 6 x 2 g

4682K

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	..	..	*130.45	6.40	Comfeel SeaSorb Filler 3740 [CT]

▪ DRESSING ALGINATE SUPERFICIAL WOUND

Note This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

dressing alginate superficial wound 7.5 cm x 12 cm dressing, 10

4683L

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	88.05	6.40	Kaltostat 168212 [CC]

▪ DRESSING ALGINATE SUPERFICIAL WOUND

Note This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing alginate superficial wound 15 cm x 20 cm dressing, 10

4691X

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	273.44	6.40	Algisite M 66000521 [SN]

dressing alginate superficial wound 10 cm x 10 cm dressing, 10

4700J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	113.67	6.40	Algisite M 66000520 [SN]

dressing alginate superficial wound 5 cm x 5 cm dressing, 10

4699H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	49.57	6.40	Kaltostat 168210 [CC]
		..	60.59	6.40	Algisite M 66000519 [SN]

▪ DRESSING ALGINATE SUPERFICIAL WOUND

Note This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing alginate superficial wound 10 cm x 10 cm dressing, 1

4831G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10	1	..	*81.95	6.40	Sorbsan 1410 [UM]
		..	*87.15	6.40	Comfeel SeaSorb Dressing 3710 [CT]

dressing alginate superficial wound 5 cm x 5 cm dressing, 1

4684M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	1	..	*47.05	6.40	Comfeel SeaSorb Dressing 3705 [CT]

▪ DRESSING ALGINATE WITH MANUKA HONEY

Note Suitable for yellow sloughy infected and malodorous wounds.

dressing alginate with manuka honey 2.5 cm x 20 cm ribbon, 5

10857K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	4	..	114.85	6.40	Algivon Plus Ribbon & Probe CR4231 [DJ]

dressing alginate with manuka honey 10 cm x 10 cm dressing, 5

10849B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	4	..	63.56	6.40	Algivon Plus CR4225 [DJ]

▪ DRESSING FILM

dressing film 6 cm x 7 cm dressing, 8

4686P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	19.11	6.40	Nexcare Tegaderm Transparent H1624 [MM]

dressing film 10 cm x 12 cm dressing, 4

4687Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	22.59	6.40	Nexcare Tegaderm Transparent H1626 [MM]

dressing film 15 cm x 20 cm dressing, 1

4688R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	6	..	..	*32.17	6.40	Tegaderm Transparent 1628 [MM]

▪ DRESSING FILM

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing film 10 cm x 12 cm dressing, 10

4893M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	38.38	6.40	Op-Site Flexigrid 4629 [SN]

▪ DRESSING FILM ISLAND

dressing film island 5 cm x 7 cm dressing, 1

4689T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	..	..	*19.55	6.40	Tegaderm Transparent Island 3582 [MM]

dressing film island 9 cm x 10 cm dressing, 1

4690W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	..	..	*29.55	6.40	Tegaderm Transparent Island 3586 [MM]

▪ DRESSING FILM ISLAND

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing film island 5 cm x 7.2 cm dressing, 5

4898T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*32.65	6.40	Cutifilm Plus 36361370 [SN]

dressing film island 8 cm x 10 cm dressing, 5

4899W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*49.21	6.40	Cutifilm Plus 36361371 [SN]

▪ DRESSING FOAM HEAVY EXUDATE

Note This dressing should remain in place until saturated or up to a maximum of 7 days. Allow a minimum of 2 cm to 3 cm in excess of the wound size of the dressing around the wound.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing foam heavy exudate 10 cm x 10 cm dressing, 10

4795J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	141.63	6.40	Allevyn 66007637 [SN]

▪ DRESSING FOAM MODERATE EXUDATE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing foam moderate exudate cavity conforming foam, 20 g sachet

4694C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	1	..	98.92	6.40	Cavicare 4563 [SN]

▪ DRESSING FOAM MODERATE EXUDATE

Note This dressing should remain in place until saturated or up to a maximum of 7 days. Allow a minimum of 2 cm to 3 cm in excess of the wound size of the dressing around the wound.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing foam moderate exudate 12.5 cm x 12.5 cm dressing, 10

4590N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	141.33	6.40	Allevyn Adhesive 66000044 [SN]

▪ DRESSING FOAM WITH SILICONE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing foam with silicone 15.4 cm x 15.4 cm dressing, 10

10023M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	116.86	6.40	Allevyn Life 66801069 [SN]

dressing foam with silicone 10.3 cm x 10.3 cm dressing, 10

10017F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	60.55	6.40	Allevyn Life 66801067 [SN]

dressing foam with silicone 12.9 cm x 12.9 cm dressing, 10

10029W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	85.30	6.40	Allevyn Life 66801068 [SN]

dressing foam with silicone 21 cm x 21 cm dressing, 10

10021K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	232.10	6.40	Allevyn Life 66801070 [SN]

▪ DRESSING FOAM WITH SILICONE AND SILVER

Note Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

Authority required

Wounds

Clinical criteria:

- Patient must have a wound where there is evidence of critical colonisation; OR
- Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressing foam with silicone and silver 10 cm x 10 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2439J	‡1	..	..	104.62	6.40	Mepilex Ag [MH]

dressing foam with silicone and silver 10 cm x 10 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2470B	‡1	..	..	111.67	6.40	Mepilex Border Ag [MH]

▪ DRESSING FOAM WITH SILICONE HEAVY EXUDATE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing foam with silicone heavy exudate 10 cm x 10 cm dressing, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4196W	‡1	..	..	80.43	6.40	Allevyn Gentle 66800248 [SN]

dressing foam with silicone heavy exudate 10 cm x 10 cm dressing, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4230P	‡1	..	..	80.43	6.40	Allevyn Gentle Border 66800270 [SN]

dressing foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4207K	‡1	..	..	57.32	6.40	Allevyn Gentle Border 66800269 [SN]

▪ DRESSING FOAM WITH SILICONE HEAVY EXUDATE

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressing foam with silicone heavy exudate 10 cm x 10 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4643J	‡1	..	..	42.85	6.40	Mepilex Border 295300 [MH]

dressing foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4642H	‡1	..	..	32.26	6.40	Mepilex Border 295200 [MH]

▪ DRESSING FOAM WITH SILICONE LIGHT EXUDATE

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressing foam with silicone light exudate 6 cm x 8.5 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4644K	‡1	..	..	29.91	6.40	Mepilex Lite 284000 [MH]

dressing foam with silicone light exudate 10 cm x 10 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4645L	‡1	..	..	38.73	6.40	Mepilex Lite 284100 [MH]

▪ DRESSING FOAM WITH SILICONE MODERATE EXUDATE

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressing foam with silicone moderate exudate 10 cm x 10 cm dressing, 5

4626L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	42.85	6.40	Mepilex 294100 [MH]

▪ DRESSING FOAM WITH SILVER

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

Authority required

Wounds

Clinical criteria:

- Patient must have a wound where there is evidence of critical colonisation; OR
- Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressing foam with silver 12.5 cm x 12.5 cm dressing, 10

4258D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	267.18	6.40	Allevyn Ag Adhesive 66800078 [SN]

dressing foam with silver 12.5 cm x 12.5 cm dressing, 10

4270R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	267.18	6.40	Allevyn Ag Gentle Border 66800462 [SN]

dressing foam with silver 10 cm x 10 cm dressing, 10

4255Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	214.69	6.40	Allevyn Ag Adhesive 66800075 [SN]

dressing foam with silver 10 cm x 10 cm dressing, 10

4259E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	218.86	6.40	Allevyn Ag Non-Adhesive 66800086 [SN]

dressing foam with silver 10 cm x 10 cm dressing, 10

4266M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	214.69	6.40	Allevyn Ag Gentle Border 66800461 [SN]

dressing foam with silver 7.5 cm x 7.5 cm dressing, 10

4252T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	145.29	6.40	Allevyn Ag Adhesive 66800073 [SN]

dressing foam with silver 7.5 cm x 7.5 cm dressing, 10

4263J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	145.29	6.40	Allevyn Ag Gentle Border 66800460 [SN]

▪ DRESSING GAUZE ABSORBENT

dressing gauze absorbent 5 cm x 5 cm pad, 100

4707R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.69	6.40	Handy 71117-05 [BV]

dressing gauze absorbent 10 cm x 10 cm pad, 100

4708T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	32.42	6.40	Handy 71117-06 [BV]

▪ DRESSING GAUZE EYE

dressing gauze eye pad, 12 pads

4768Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	16.66	6.40	Curity 4112 [KE]

▪ DRESSING GAUZE PARAFFIN

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler

cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing gauze paraffin 10 cm x 10 cm dressing, 10

4759L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	25.50	6.40	Jelonet 7404 [SN]

▪ DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE ACETATE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing gauze paraffin with chlorhexidine acetate 10 cm x 10 cm dressing, 10

4845B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	32.48	6.40	Bactigras 7457 [SN]

▪ DRESSING HYDROACTIVE DEBRIDEMENT

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 4 cm, 10, 1

4949L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	82.42	6.40	TenderWet 24 Active 609210 [HR]

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 7.5 cm x 7.5 cm, 10, 1

4950M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	110.02	6.40	TenderWet 24 Active 609213 [HR]

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 5.5 cm, 10, 1

4948K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	84.28	6.40	TenderWet Active Cavity 609272 [HR]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm (foam alternative) dressing, 10

4692Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	55.07	6.40	CombiDERM 651031 [CC]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 18 cm (foam alternative) dressing, 5

4693B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	70.45	6.40	CombiDERM 651027 [CC]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm dressing: island, 5 dressings

4696E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	128.74	6.40	Tielle MTL103 [KI]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 11 cm x 11 cm dressing: island, 10 dressings

4695D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	106.38	6.40	Tielle MTL101E [KI]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 15 cm waterproof pad, 5

4928J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	83.84	6.40	Biatain Non-adhesive 3413 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 12 cm x 12 cm waterproof pad, 10

4929K	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	93.39	6.40	Biatain Adhesive 3420 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm waterproof pad, 10

4927H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	85.19	6.40	Biatain Non-adhesive 3410 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm waterproof pad, 5

4930L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	90.54	6.40	Biatain Adhesive 3423 [CT]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND LIGHT EXUDATE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing hydroactive superficial wound light exudate 5 cm x 6 cm dressing, 10

4905E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	68.37	6.40	Allevyn Thin 66047576 [SN]

dressing hydroactive superficial wound light exudate 10 cm x 10 cm dressing, 5

4906F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*121.77	6.40	Allevyn Thin 66047578 [SN]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND MODERATE EXUDATE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing hydroactive superficial wound moderate exudate 10 cm x 10 cm dressing, 5

4886E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*92.49	6.40	Cutinova Hydro 66047443 [SN]

dressing hydroactive superficial wound moderate exudate 5 cm x 6 cm dressing, 10

4885D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	56.44	6.40	Cutinova Hydro 66047441 [SN]

▪ DRESSING HYDROCOLLOID CAVITY WOUND

Note This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

dressing hydrocolloid cavity wound paste, 30 g

4896Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	..	..	*137.15	6.40	DuoDERM Paste 187930 [CC]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4907G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	70.45	6.40	DuoDERM Extra Thin 187955 [CC]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrocolloid superficial wound light exudate 9 cm x 14 cm dressing, 10

4889H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	82.09	6.40	Comfeel Plus Transparent 3536 [CT]

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4924E

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	68.69	6.40	Comfeel Plus Transparent 3533 [CT]

dressing hydrocolloid superficial wound light exudate 5 cm x 7 cm dressing, 10

4888G

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	41.89	6.40	Comfeel Plus Transparent 3530 [CT]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4947J

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	48.32	6.40	Hydrocoll Thin 900758 [HR]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE

Note This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

dressing hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5

4920Y

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	1	..	*209.61	6.40	DuoDERM CGF 187662 [CC]

dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5

4897R

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2	1	..	*79.25	6.40	DuoDERM CGF 187660 [CC]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE

Note This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10

4921B

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	93.46	6.40	Replicare Ultra 66000434 [SN]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE

Note This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressing hydrocolloid superficial wound moderate exudate 15 cm x 15 cm dressing, 10

4946H

Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
‡1	1	..	86.99	6.40	Hydrocoll 900936 [HR]

dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10

4945G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	48.32	6.40	Hydrocoll 900744 [HR]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE

Note This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrocolloid superficial wound moderate exudate 7cm (butterfly shape) dressing, 1

4678F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*55.35	6.40	Comfeel Plus Pressure Relieving 3350 [CT]

DRESSING-HYDROCOLLOID (SUPERFICIAL WOUND-MODERATE EXUDATE) Dressings with alginate 10 cm x 10 cm, 10, 1

4923D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	79.80	6.40	Comfeel Plus Ulcer Dressing 3110 [CT]

dressing hydrocolloid superficial wound moderate exudate 10cm (round) dressing, 1

4679G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	5	..	..	*59.45	6.40	Comfeel Plus Pressure Relieving 3353 [CT]

▪ DRESSING HYDROFIBRE ALTERNATE TO ALGINATES

dressing hydrofibre alternate to alginates 10 cm x 10 cm dressing, 10

10837J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	120.20	6.40	Aquacel Foam Non-Adhesive [CC]

dressing hydrofibre alternate to alginates 10 cm x 10 cm dressing, 10

2797F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	97.05	6.40	Aquacel Extra 420672 [CC]

dressing hydrofibre alternate to alginates 2 g (30 cm) rope, 5 x 2 g

4698G	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	81.35	6.40	Aquacel 403770 [CC]

dressing hydrofibre alternate to alginates 12.5 cm x 12.5 cm dressing, 10

10832D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	116.73	6.40	Aquacel Foam Adhesive [CC]

dressing hydrofibre alternate to alginates 15 cm x 15 cm dressing, 5

2803M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	1	..	*195.51	6.40	Aquacel Extra 420673 [CC]

▪ DRESSING HYDROFIBRE GELLING FIBRE

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing hydrofibre gelling fibre 2 cm x 45 cm rope, 5

2462N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	87.24	6.40	Durafiber 66800563 [SN]

dressing hydrofibre gelling fibre 10 cm x 10 cm dressing, 10

2486W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	1	..	103.62	6.40	Durafiber 66800560 [SN]

dressing hydrofibre gelling fibre 15 cm x 15 cm dressing, 5

2445Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡2	1	..	*211.59	6.40	Durafiber 66800561 [SN]

▪ DRESSING HYDROFIBRE WITH SILVER

Authority required

Wounds

Clinical criteria:

- Patient must have a wound where there is evidence of critical colonisation; OR
- Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressing hydrofibre with silver 2 cm x 45 cm rope, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10105W	‡1	1	..	211.81	6.40	Aquacel Ag 403771 [CC]

dressing hydrofibre with silver 10 cm x 10 cm dressing, 10

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10097K	‡1	1	..	250.75	6.40	Aquacel Ag 403708 [CC]

dressing hydrofibre with silver 15 cm x 15 cm dressing, 5

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
10098L	‡1	1	..	268.39	6.40	Aquacel Ag 403710 [CC]

▪ DRESSING HYDROGEL

dressing hydrogel 10 cm x 10 cm dressing, 20

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
2471C	1	..	..	108.93	6.40	Sorbact Absorption Dressing S98222 [QL]

▪ DRESSING HYDROGEL AMORPHOUS

Note This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

dressing hydrogel amorphous gel, 50 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4914P	3	3	..	*34.30	6.40	Solugel 10336 [JJ]

dressing hydrogel amorphous gel, 3 x 30 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4913N	3	1	..	*93.52	6.40	DuoDERM Gel H7987 [CC]

▪ DRESSING HYDROGEL AMORPHOUS

Note This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrogel amorphous gel, 10 x 15 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4912M	‡1	1	..	63.87	6.40	DuoDERM Gel 187990 [CC]
			..	70.79	6.40	Comfeel Purilon Gel 3900 [CT]

▪ DRESSING HYDROGEL AMORPHOUS

Note This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing hydrogel amorphous gel, 25 g

	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
4894N	4	3	..	*73.31	6.40	Intrasite Gel 7313 [SN]

dressing hydrogel amorphous gel, 50 g

4599C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	3	3	..	*35.62	6.40	SoloSite Gel 36361338 [SN]

▪ DRESSING HYDROGEL FOAM

dressing hydrogel foam 10 cm x 10 cm dressing, 10

2533H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	77.48	6.40	Sorbact Foam Dressing S98310 [QL]

▪ DRESSING HYDROGEL RIBBON

dressing hydrogel ribbon 5 cm x 200 cm dressing, 10

2529D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	108.93	6.40	Sorbact Ribbon Gauze S98120 [QL]

dressing hydrogel ribbon 1 cm x 50 cm dressing, 20

2512F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	1	..	..	112.43	6.40	Sorbact Ribbon Gauze S98118 [QL]

▪ DRESSING HYDROGEL SHEET

Note This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

dressing hydrogel sheet 9.5 cm x 10.2 cm dressing, 5

4911L	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*80.89	6.40	Nu-Gel 2497 [KI]

▪ DRESSING HYDROGEL SHEET

Note This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressing hydrogel sheet 10 cm x 10 cm dressing, 5

4806Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*53.45	6.40	Hydrosorb 900854 [HR]

▪ DRESSING NON ADHERENT

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 5 cm x 7.5 cm, 10, 1

4243H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	63.09	6.40	Mepitel 290510 [MH]

DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 7.5 cm x 10 cm, 10, 1

4244J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	103.09	6.40	Mepitel 290710 [MH]

▪ DRESSING NON ADHERENT

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressing non adherent 7.5 cm x 10 cm dressing, 10

4944F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	18.76	6.40	Atrauman 499513 [HR]

▪ DRESSING NON ADHERENT

Note Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing non adherent 10 cm x 10 cm dressing, 5

4862X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*28.93	6.40	Cutilin Non-Stick Wound Pad 36361375 [SN]

dressing non adherent 10 cm x 10 cm dressing, 10

4861W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	39.21	6.40	Melolin 66974933 [SN]

dressing non adherent 5 cm x 5 cm dressing, 5

4819P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*19.89	6.40	Cutilin Non-Stick Wound Pad 36361374 [SN]

dressing non adherent 5 cm x 5 cm dressing, 5

4860T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	2	..	..	*21.13	6.40	Melolin 36361357 [SN]

▪ DRESSING TULLE NON GAUZE PARAFFIN

dressing tulle non gauze paraffin 7.6 cm x 7.6 cm dressing, 1

4909J	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	10	1	..	*19.15	6.40	Adaptic 2012 [KI]

▪ DRESSING WITH SILVER

Note Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

Authority required

Wounds

Clinical criteria:

- Patient must have a wound where there is evidence of critical colonisation; OR
- Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressing with silver 12.5 cm x 12.5 cm hydroactive dressing, 5

4647N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	179.15	6.40	Biatain Ag 9632 [CT]

dressing with silver 10 cm x 10 cm hydroactive dressing, 5

4646M	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	165.14	6.40	Biatain Ag 9622 [CT]

▪ DRESSING WITH SILVER

Note Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

Authority required

Wounds

Clinical criteria:

- Patient must have a wound where there is evidence of critical colonisation; OR
- Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressing with silver 10 cm x 10 cm tulle dressing, 3

4648P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	43.95	6.40	Atrauman Ag 499572 [HR]

▪ GAUZE AND COTTON TISSUE COMBINE ROLL

gauze and cotton tissue combine roll 10 cm x 10 m roll: wrapped pack, 1 pack

4761N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.47	6.40	JJ 12010 [JJ]

gauze and cotton tissue combine roll 9 cm x 10 m roll: wrapped pack, 1 pack

4767X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.78	6.40	BSN 2902165 [BV]

▪ POVIDONE-IODINE

povidone-iodine 9.5 cm x 9.5 cm dressing, 25

10847X	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	2	..	77.64	6.40	Inadine [KI]

▪ SODIUM CHLORIDE + HYPOCHLOROUS ACID + SODIUM HYPOCHLORITE

sodium chloride 0.022% + hypochlorous acid 0.004% + sodium hypochlorite 0.004% irrigation solution, 250 mL

11134B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	3	..	30.44	6.40	Microdacyn [TF]

▪ TAPE NON WOVEN RETENTION POLYACRYLATE

tape non woven retention polyacrylate 2.5 cm x 9.1 m tape, 1 roll

4915Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	16.70	6.40	Medipore 2961 [MM]

▪ TAPE NON WOVEN RETENTION POLYACRYLATE

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

tape non woven retention polyacrylate 2.5 cm x 10 m tape, 1 roll

4917T	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.11	6.40	Mefix 310250 [MH]

▪ TAPE PLASTER ADHESIVE ELASTIC

tape plaster adhesive elastic 5 cm x 2.5 m tape, 1 roll

4781P	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	23.56	6.40	Leukoplast 01072-00 [BV]

tape plaster adhesive elastic 7.5 cm x 2.5 m tape, 1 roll

4782Q	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	27.24	6.40	Leukoplast 01073-00 [BV]

tape plaster adhesive elastic 2.5 cm x 2.5 m tape, 1 roll

4780N	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	17.62	6.40	Leukoplast 01071-00 [BV]

▪ TAPE PLASTER ADHESIVE HYPOALLERGENIC

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4788B	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.47	6.40	Leukoflex 1124 [BV]

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4789C	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	21.79	6.40	Leukosilk 1024 [BV]

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4790D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	20.96	6.40	Leukopor 2474 [BV]

tape plaster adhesive hypoallergenic 1.9 cm x 7.3 m dispenser tape, 1 roll

4849F	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.12	6.40	Nexcare Gentle Paper First Aid Tape 789 [MM]

tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll

4783R	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.03	6.40	Leukopor 2471 [BV]

tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll

4785W	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.32	6.40	Leukosilk 1021 [BV]

tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll

4787Y	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	17.97	6.40	Leukosilk 1022 [BV]

tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll

4794H	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	17.44	6.40	Leukopor 2472 [BV]

tape plaster adhesive hypoallergenic 1.9 cm x 5.4 m dispenser tape, 1 roll

4848E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	15.12	6.40	Nexcare Durable Cloth First Aid Tape 799 [MM]

▪ TAPE PLASTER ADHESIVE WITH SILICONE

Note Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

tape plaster adhesive with silicone 4 cm x 1.5 m tape, 1 roll

4240E	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	24.09	6.40	Mepitac 298400 [MH]

tape plaster adhesive with silicone 2 cm x 3 m tape, 1 roll

4239D	Max.Qty Packs	No. of Rpts	Premium $	DPMQ $	MRVSN $	Brand Name and Manufacturer
	‡1	..	..	24.09	6.40	Mepitac 298300 [MH]

Extemporaneously Prepared Benefits

Drug Tariff

Drug	Standard	Recovery Prices			
		0.1 g/mL $	1 g/mL $	10 g/mL $	100 g/mL $
Acacia Mucilage (by weight)	APF 15	0.02	0.12	0.96	8.49
Acacia, powdered	BP	0.03	0.22	1.79	15.91
Acetic Acid (33 per cent)	BP	0.01	0.06	0.46	4.07
Acetic Acid (6 per cent)	BP	0.01	0.02	0.15	1.31
Acetic Acid Glacial BP	BP	0.02	0.14	1.09	9.69
Acetone (use as additive only)	BP	0.03	0.20	1.63	14.50
Alum	BP	0.01	0.07	0.59	5.25
Aluminium Acetate Solution	BP	0.02	0.17	1.38	12.27
Anise Oil BP	BP	0.18	1.44	11.52	102.44
Anise Water Concentrated 1 in 40	BP	0.01	0.07	0.57	5.03
Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.01	0.03	0.24	2.10
Ascorbic Acid (for use only as an ingredient of ferrous sulfate mixtures)	BP	0.37	2.99	23.94	212.76
Aspirin	BP	0.14	1.15	9.22	81.94
Belladonna Tincture	BP	0.10	0.81	6.44	57.28
Benzocaine	BP	0.12	0.97	7.76	68.94
Benzoic Acid	BP	0.06	0.48	3.80	33.80
Benzoic Acid Compound Ointment	APF	0.02	0.16	1.26	11.22
Benzoic Acid Solution	BP	0.02	0.14	1.09	9.73
Benzoin Compound Tincture	BP	0.05	0.43	3.47	30.81
Boric Acid (use as additive only)	BP	0.02	0.19	1.55	13.79
Boric Acid, Olive Oil and Zinc Oxide Ointment	QHF	0.02	0.14	1.09	9.67
Calcium Hydroxide	BP	0.10	0.83	6.64	59.00
Calcium Hydroxide Solution	BP	0.01	0.02	0.17	1.52
Castor Oil (use as additive only)	BP	0.02	0.18	1.41	12.50
Cetomacrogol Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.01	0.04	0.28	2.48
Cetrimide Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.02	0.17	1.37	12.21
Chlorhexidine Acetate (use as additive only)	BP	0.63	5.03	40.21	357.42
Chlorhexidine Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.03	0.24	1.95	17.36
Chloroform (use as additive only)	BP	0.09	0.72	5.77	51.29
Chloroform Spirit	BP	0.01	0.08	0.67	5.94
Chloroform Water Concentrated 1 in 40	APF 15	0.01	0.11	0.84	7.45
Citric Acid Monohydrate	BP	0.04	0.29	2.28	20.25
Coal Tar	BP	0.28	2.21	17.70	157.34
Coal Tar Solution	BP	0.02	0.16	1.25	11.15
Cocaine Hydrochloride	BP	5.41	43.26	346.09	3076.38
Coconut Oil	BP	0.01	0.05	0.42	3.73
Codeine Linctus	APF	0.01	0.10	0.79	7.03
Codeine Phosphate (may only be prescribed in linctuses, mixtures or mixtures for children)	BP	3.82	30.58	244.67	2174.84
Collodion Flexible	BP	0.19	1.55	12.37	109.92
Dithranol	BP	4.31	34.48	275.84	2451.94
Emulsifying Ointment (for use only as a base combined with active ingredients)	BP	0.01	0.09	0.71	6.27
Ephedrine Hydrochloride (may only be prescribed in nasal instillations)	BP	2.05	16.43	131.45	1168.43

Drug	Standard	Recovery Prices			
		0.1 g/mL $	1 g/mL $	10 g/mL $	100 g/mL $
Ethanol (90 per cent) (use as additive only)	BP	0.01	0.04	0.28	2.45
Ethanol (96 per cent) (use as additive only)	BP	0.01	0.04	0.35	3.10
Ether Solvent (use as additive only)	BP	0.25	1.97	15.73	139.82
Eucalyptus Oil (use as additive only)	BP	0.02	0.18	1.42	12.64
Ferrous Sulfate	BP	0.04	0.29	2.32	20.59
Formaldehyde Solution	BP	0.07	0.53	4.26	37.86
Gentian Alkaline Mixture	APF	0.01	0.09	0.68	6.00
Glycerol	BP	0.02	0.12	0.98	8.72
Honey Purified (use as additive only)	BP 1993	0.01	0.03	0.27	2.44
Hydroxybenzoate Compound Solution	APF	0.07	0.59	4.73	42.08
Iodine	BP	0.37	2.98	23.85	211.97
Iodine Alcoholic Solution	BP	0.04	0.28	2.26	20.11
Iodine Aqueous Oral Solution	BP	0.03	0.26	2.11	18.72
Kaolin Mixture	BPC 1968	0.03	0.21	1.71	15.19
Kaolin and Opium Mixture	APF 14	0.01	0.10	0.82	7.27
Lactic Acid	BP	0.36	2.87	22.94	203.95
Lavender Spike Oil	BPC 1968	0.13	1.04	8.32	73.91
Liquorice Liquid Extract	BP	0.03	0.23	1.84	16.37
Magnesium Carbonate Light	BP	0.05	0.37	2.92	25.99
Magnesium Sulfate (may only be prescribed for other than oral use)	BP	0.01	0.03	0.24	2.10
Magnesium Trisilicate	BP	0.05	0.36	2.91	25.82
Menthol, Racemic or Levomenthol	BP	0.25	2.02	16.19	143.87
Methyl Hydroxybenzoate	BP	0.41	3.28	26.22	233.03
Methyl Hydroxybenzoate Solution	APF	0.04	0.35	2.80	24.87
Methylated Industrial Spirit (use as additive only)	BP	0.01	0.01	0.08	0.73
Olive Oil (use as additive only)	BP	0.02	0.14	1.08	9.62
Paraffin Hard	BP	0.05	0.41	3.29	29.28
Paraffin Light Liquid	BP	0.02	0.17	1.39	12.32
Paraffin Liquid (use as additive only)	BP	0.01	0.06	0.51	4.56
Paraffin Soft White	BP	0.01	0.05	0.42	3.71
Paraffin Soft Yellow	BP	0.01	0.05	0.42	3.75
Peppermint Oil (use as additive only)	BP	0.07	0.57	4.55	40.44
Peppermint Water Concentrated 1 in 40 (use as additive only)	APF 16	0.04	0.34	2.72	24.17
Phenobarbitone Sodium (may only be prescribed for the treatment of epilepsy)	BP	9.37	74.92	599.36	5327.61
Phenol Liquefied (not available for ear drops)	BP	0.13	1.02	8.17	72.64
Podophyllum Resin	BP	3.78	30.25	242.03	2151.34
Potassium Citrate	BP	0.02	0.19	1.53	13.64
Potassium Iodide	BP	0.14	1.11	8.88	78.94
Potassium Permanganate	BP	0.04	0.31	2.44	21.65
Propyl Hydroxybenzoate	BP	0.42	3.35	26.78	238.01
Propylene Glycol	BP	0.02	0.12	0.95	8.48
Red Syrup	APF 15	0.02	0.13	1.04	9.23
Resorcinol	BP	0.42	3.32	26.54	235.88
Salicylic Acid	BP	0.05	0.40	3.18	28.25
Salicylic Acid Ointment	APF	0.02	0.17	1.38	12.23
Salicylic Acid Ointment	BP	0.02	0.17	1.38	12.23
Simple Ointment (white) (for use only as a base combined with active ingredients)	BP	0.02	0.14	1.11	9.88
Simple Ointment (yellow) (for use only as a base combined with active ingredients)	BP	0.02	0.14	1.11	9.88
Sodium Bicarbonate	BP	0.04	0.28	2.24	19.91
Sodium Chloride	BP	0.02	0.17	1.34	11.88
Sodium Chloride Solution	BP	0.01	0.01	0.09	0.84
Sodium Citrate	BP	0.04	0.28	2.23	19.81
Sodium Thiosulfate (use as additive only)	BP	0.04	0.34	2.74	24.37
Starch	BP	0.02	0.19	1.55	13.79
Sulfur Ointment (for use only as a base combined with active ingredients)	BP 1980	0.02	0.15	1.21	10.75
Sulfur Precipitated	BP 1980	0.03	0.23	1.86	16.49
Syrup	BP	0.01	0.05	0.42	3.71
Talc Purified, sterilised	BP	0.06	0.46	3.71	32.94
Thymol	BP	0.46	3.71	29.66	263.61
Thymol Compound Mouth Wash	APF 15	0.01	0.11	0.89	7.91

Drug	Standard	Recovery Prices			
		0.1 g/mL $	1 g/mL $	10 g/mL $	100 g/mL $
Tragacanth Compound Powder	BP 1980	0.07	0.57	4.58	40.73
Tragacanth Mucilage	APF 13	0.01	0.07	0.58	5.14
Tragacanth Mucilage	BPC 1973	0.01	0.06	0.51	4.56
Tragacanth, powdered	BP	0.36	2.84	22.72	201.94
Trichloroacetic Acid	BP 1980	0.33	2.65	21.23	188.68
Triethanolamine	BP	0.12	0.96	7.68	68.28
Water For Injections, sterilised (b) (extemporaneously prepared eye drops and eye lotions)	BP				
Water Purified	BP	0.01	0.01	0.08	0.69
Wool Alcohols Ointment (white) (for use only as a base combined with active ingredients)	BP	0.02	0.17	1.33	11.86
Wool Alcohols Ointment (yellow) (for use only as a base combined with active ingredients)	BP	0.02	0.19	1.48	13.18
Wool Fat	BP	0.02	0.12	0.97	8.63
Wool Fat Hydrous	BP	0.03	0.25	2.03	18.01
Zinc Compound Paste	BP	0.05	0.40	3.17	28.17
Zinc Cream (for use only as a base combined with active ingredients)	BP	0.01	0.08	0.61	5.39
Zinc Oxide	BP	0.03	0.21	1.66	14.79
Zinc Sulfate	BP	0.04	0.28	2.21	19.63
Zinc and Salicylic Acid Paste	BP	0.04	0.32	2.53	22.47

Container Prices

Type	Container	Price $
Dispensing Bottles	25mL	0.64
Dispensing Bottles	50mL	0.53
Dispensing Bottles	100mL	0.87
Dispensing Bottles	200mL	1.03
Dispensing Bottles	500mL	1.28
Poison Bottles	25mL	0.67
Poison Bottles	50mL	0.54
Poison Bottles	100mL	0.79
Poison Bottles	200mL	1.02
Poison Bottles	500mL	1.69
Dropper Containers (Glass)	15mL	1.21
Dropper Containers (Polythene)	15mL	0.98
	150ml	0.83
Screw Cap Jars	25g	0.90
Screw Cap Jars	50g	0.96
Screw Cap Jars	100g	0.99
Screw Cap Jars	200g	0.85
Screw Cap Jars	500g	2.19
	25ml	0.41

Standard Formula Preparations

Code	Item	Reference	DPMQ $	MRVSN $
	Creams			
	(Maximum Quantity 100 g and 1 Repeat)			
7502W	Salicylic Acid and Sulfur Aqueous	APF	13.47	15.04
	Dusting Powders			
	(Maximum Quantity 100 g and 1 Repeat)			
7458M	Zinc, Starch and Talc	APF 15 & BPC 1973	36.61	38.18
	Ear Drops			
	(Maximum Quantity 15 ml and 2 Repeats)			
7643G	Aluminium Acetate	BP	12.24	13.81
7642F	Aluminium Acetate	APF	11.47	13.04
7314Y	Sodium Bicarbonate	APF & BP	11.01	12.58
7313X	Spirit	APF	10.44	12.01
	Inhalations			
	(Maximum Quantity 50 ml and 1 Repeat)			
7484X	Benzoin and Menthol	APF	29.08	30.65
7308P	Menthol	APF	13.13	14.70
7310R	Menthol and Eucalyptus	BP1980	14.27	15.84
	Linctuses containing Codeine Phosphate			
	(Maximum Quantity 100 ml and 0 Repeat)			
7530H	Codeine	APF	17.09	18.66
	Lotions			
	(Maximum Quantity 200 ml and 2 Repeats)			
7709R	Aluminium Acetate Aqueous	APF	12.90	14.47
	Mixtures, Other			
	(Maximum Quantity 200 ml and 4 Repeats)			
7604F	Gentian Alkaline	APF	22.22	23.79
7348R	Kaolin	BPC 1968	40.59	39.50
7301G	Kaolin and Opium	APF 14	24.76	26.33
7342K	Magnesium Trisilicate	BPC 1968	21.34	22.91
7343L	Magnesium Trisilicate and Belladonna	BPC 1968	27.63	29.20
	Mouth Washes			
	(Maximum Quantity 200 ml and 1 Repeat)			
7457L	Thymol Compound	APF 15	26.03	27.60
	Ointments, Waxes			
	(Maximum Quantity 100 g and 1 Repeat)			
7914M	Benzoic Acid Compound	APF & BP	21.40	22.97
7902X	Boric Acid, Olive Oil and Zinc Oxide	QHF	19.85	21.42
7926E	Salicylic Acid	APF	22.41	23.98
7928G	Salicylic Acid (extemporaneous formula)	BP	22.41	23.98
	Paints			
	(Maximum Quantity 25 ml and 1 Repeat)			
7567G	Podophyllin Compound	APF 16 & BP	131.97	39.50
7568H	Salicylic Acid	APF	41.77	39.50
	Pastes, Other			
	(Maximum Quantity 100 g and 1 Repeat)			
7558T	Zinc	APF & BP	38.35	39.50
	Powders for Internal Use			
	(Maximum Quantity 100 g and 2 Repeats)			
7545D	Magnesium Trisilicate	BP	35.86	37.43

Codes, Maximum Quantities, and Number of Repeats for Extemporaneously Prepared Benefits

Code	Preparation	Maximum Quantity	Number of Repeats
13Q	Creams	100 g	1
48M	Dusting Powders	100 g	1
15T	Ear Drops	15 ml	2
19B	Eye Drops containing Cocaine Hydrochloride	15 ml	..
22E	Eye Drops, Other	15 ml	5
23F	Eye Lotions	200 ml	2
29M	Inhalations	50 ml	1
64J	Linctuses containing Codeine Phosphate	100 ml	..
34T	Linctuses, Other	100 ml	2
39C	Lotions	200 ml	2
65K	Mixtures containing Codeine Phosphate	200 ml	..
66L	Mixtures for Children containing Codeine Phosphate	100 ml	..
41E	Mixtures for Children, Other	100 ml	4
40D	Mixtures, Other	200 ml	4
30N	Mouth Washes	200 ml	1
42F	Nasal Instillations	15 ml	2
43G	Ointments, Waxes	100 g	1
44H	Paints	25 ml	1
63H	Pastes containing Cocaine Hydrochloride	25 g	..
45J	Pastes, Other	100 g	1
49N	Powders for Internal Use	100 g	2
52R	Solutions	200 ml	2

Index of Manufacturers' Code

Code	Manufacturer
AB	Abbott Australasia Pty Ltd
AE	AFT Pharmaceuticals Pty Ltd
AF	Alphapharm Pty Ltd
AG	Allergan Australia Pty Limited
AL	Alphapharm Pty Ltd
AN	Amgen Australia Pty Limited
AP	AstraZeneca Pty Ltd
AS	Aspen Pharmacare Australia Pty Limited
AT	Actelion Pharmaceuticals Australia Pty Ltd
AV	sanofi-aventis Australia Pty Ltd
BB	Blackmores Limited
BD	Biogen Australia Pty Ltd
BE	Beiersdorf Australia Ltd
BG	Sandoz Pty Ltd
BI	Biotech Pharmaceuticals Pty Ltd
BN	Bayer Australia Ltd
BQ	Bristol-Myers Squibb Australia Pty Ltd
BR	B. Braun Australia Pty Ltd
BV	BSN medical (Aust.) Pty Ltd
BX	Baxter Healthcare Pty Limited
BY	Boehringer Ingelheim Pty Ltd
BZ	Boucher & Muir Pty Ltd
CC	ConvaTec A Division of Bristol-Myers Squibb Australia Pty Ltd
CF	CNS Pharma Pty Ltd
CH	Apotex Pty Ltd
CJ	Celgene Pty Limited
CR	Pharmacor Pty Limited
CS	Seqirus (Australia) Pty Ltd
CT	Coloplast Pty Ltd
CU	Care Pharmaceuticals Pty Limited
CX	Contact Lens Centre Australia Limited
DE	Stallergenes Australia Pty Ltd
DJ	De Fries Industries Pty Ltd
DO	Aurobindo Pharma (Australia) Pty Limited
DQ	Church & Dwight (Australia) Pty Ltd
DV	Medical Developments International Limited
DZ	Medsurge Healthcare Pty Ltd
EA	Amneal Pharmaceuticals Pty Ltd
ED	Amneal Pharmaceuticals Pty Ltd
EF	Amneal Pharmaceuticals Pty Ltd
EI	Eisai Australia Pty Ltd
EL	Eli Lilly Australia Pty Ltd
EO	Ego Pharmaceuticals Proprietary Limited
ER	Eris Pharmaceuticals (Australia) Pty Ltd
EU	Emerge Health Pty Ltd
EZ	Merz Australia Pty Ltd
FB	Pierre Fabre Medicament Australia Pty Ltd
FI	Boehringer Ingelheim Pty Ltd
FK	A. Menarini Australia Pty Limited
FM	Fawns and McAllan Proprietary Limited
FN	Fresenius Medical Care Australia Pty Ltd
FO	For Benefit Medicines Pty Ltd
FP	Ferring Pharmaceuticals Pty Limited
FR	Merck Sharp & Dohme (Australia) Pty Ltd
FX	Gedeon Richter Australia Pty Ltd
FZ	Pfizer Australia Pty Ltd
GA	Galderma Australia Pty Ltd
GC	GlaxoSmithKline Australia Pty Ltd
GH	Amdipharm Mercury (Australia) Pty Limited
GI	Gilead Sciences Pty Limited
GK	GlaxoSmithKline Australia Pty Ltd
GN	Actavis Pty Ltd
GO	BGP Products Pty Ltd
GQ	Generic Health Pty Ltd
GT	BGP Products Pty Ltd
GV	Amgen Australia Pty Limited
GX	Apotex Pty Ltd
GZ	sanofi-aventis Australia Pty Ltd

Code	Manufacturer
HB	Besins Healthcare Australia Pty Ltd
HM	Meda Pharmaceuticals Pty Ltd
HQ	Generic Health Pty Ltd
HR	Paul Hartmann Pty Ltd
HX	Sandoz Pty Ltd
IA	iNova Pharmaceuticals (Australia) Pty Limited
IB	Apotex Pty Ltd
IO	BioMarin Pharmaceutical Australia Pty Ltd
IR	Indivior Pty Ltd
IS	Ipsen Pty Ltd
IV	iNova Pharmaceuticals (Australia) Pty Limited
IX	Clinect Pty Ltd
IY	Clinect Pty Ltd
JC	Janssen-Cilag Pty Ltd
JJ	Johnson & Johnson Medical Pty Ltd
JO	Juno Pharmaceuticals Pty Ltd
JT	Johnson & Johnson Pacific Pty Limited
JU	Juno Pharmaceuticals Pty Ltd
KE	Kendall Australasia Pty Ltd
KI	KCI Medical Australia Pty Ltd
KP	Eli Lilly Australia Pty Ltd
KY	Key Pharmaceuticals Pty Ltd
LI	Luminarie Pty Ltd
LL	Astellas Pharma Australia Pty Ltd
LM	Link Medical Products Pty Ltd
LN	Aspen Pharmacare Australia Pty Limited
LO	Leo Pharma Pty Ltd
LQ	Astellas Pharma Australia Pty Ltd
LR	Cipla Australia Pty Ltd
LS	Astellas Pharma Australia Pty Ltd
LU	Lundbeck Australia Pty Ltd
LX	Lawley Pharmaceuticals Pty Ltd
LY	Eli Lilly Australia Pty Ltd
MF	Mundipharma Pty Limited
MH	Molnlycke Health Care Pty Ltd
MK	Merck Sharp & Dohme (Australia) Pty Ltd
MM	3M Pharmaceuticals Australia Pty Ltd
MT	Mentholatum Australasia Pty Ltd
MW	Biomed Aust Pty Limited
NE	Norgine Pty Limited
NF	Novo Nordisk Pharmaceuticals Pty Limited
NI	Novo Nordisk Pharmaceuticals Pty Limited
NM	Novartis Pharmaceuticals Australia Pty Limited
NO	Novo Nordisk Pharmaceuticals Pty Limited
NQ	Takeda Pharmaceuticals Australia Pty Ltd
NT	Nestle Australia Ltd
NU	Nutricia Australia Pty Limited
NV	Novartis Pharmaceuticals Australia Pty Limited
OA	Orphan Australia Pty Ltd
OB	Oral B Laboratories Pty Ltd
OC	Accord Healthcare Pty Ltd
OD	Accord Healthcare Pty Ltd
OE	Omegapharm Pty Ltd
OH	Orpharma Pty Ltd
OL	Owen Laboratories Division of Galderma Australia Pty Ltd
OM	Colgate Oral Care
ON	Orion Laboratories Pty Ltd
OS	Otsuka Australia Pharmaceutical Pty Ltd
OW	Arrow Pharma Pty Ltd
PB	Pharmaco (Australia) Limited
PE	Allergan Australia Pty Limited
PF	Pfizer Australia Pty Ltd
PK	Fresenius Kabi Australia Pty Limited
PL	The Trustee for Virgo Unit Trust (trading as Phebra)
PM	Pharmaceutical Manufacturing Company Pty Limited
PP	Petrus Pharmaceuticals Pty Ltd
PQ	PMIP Pty Ltd
PY	Procter & Gamble Pharmaceuticals Australia Pty Ltd

Code	Manufacturer
QA	Aspen Pharma Pty Ltd
QH	Cortex Health Pty Ltd
QL	Amcla Pty Limited
RA	Sun Pharma ANZ Pty Ltd
RB	Bio Revive Pty Ltd
RC	Reckitt Benckiser (Australia) Pty Limited
RF	Arrow Pharma Pty Ltd
RI	Dr Reddy's Laboratories (Australia) Pty Ltd
RN	Sun Pharma ANZ Pty Ltd
RO	Roche Products Pty Ltd
RW	Arrow Pharma Pty Ltd
RX	Servier Laboratories (Aust.) Pty Ltd
RZ	Dr Reddy's Laboratories (Australia) Pty Ltd
SA	SciGen (Australia) Pty Limited
SB	Nutricia Australia Pty Limited
SE	Servier Laboratories (Aust.) Pty Ltd
SG	Merck Serono Australia Pty Ltd
SI	Sigma Company Limited
SN	Smith & Nephew Pty Limited
SS	SSL Australia Pty Ltd
SW	sanofi-aventis Australia Pty Ltd
SY	Bayer Australia Ltd
SZ	Sandoz Pty Ltd
TB	Teva Pharma Australia Pty Limited
TD	STADA Pharmaceuticals Australia Pty Limited
TF	Te Arai BioFarma Limited
TK	Takeda Pharmaceuticals Australia Pty Ltd
TL	Tolmar Australia Pty Ltd
TM	Technipro Marketing Pty Ltd
TS	Specialised Therapeutics Australia Pty Ltd
TW	Apotex Pty Ltd
TX	Apotex Pty Ltd
UA	Actavis Pty Ltd
UC	UCB Australia Proprietary Limited
UM	Unomedical Pty Ltd
UN	Unilever Australia Limited
VE	AbbVie Pty Ltd
VF	Vitaflo Australia Pty Limited
VI	ViiV Healthcare Pty Ltd
VL	Vifor Pharma Pty Limited
VR	Vertex Pharmaceuticals (Australia) Pty Ltd
VZ	Sanofi-aventis Healthcare Pty Ltd
WA	sanofi-aventis Australia Pty Ltd
XA	Pharmaxis Ltd
XC	Southern Cross Pharma Pty Ltd
XH	MS Health Pty Ltd
XI	Alexion Pharmaceuticals Australasia Pty Ltd
XM	The Medicines Company (Australia) Pty Limited
YC	Cipla Australia Pty Ltd
YN	Mayne Pharma International Pty Ltd
YT	Mayne Products Pty Ltd
ZA	AstraZeneca Pty Ltd
ZI	Shire Australia Pty Limited
ZP	Medis Pharma Pty Ltd
ZX	Zenex Pharmaceuticals Pty Ltd

Generic/Proprietary Index

3TC(VI) *1239*
ABACAVIR 1236
ABACAVIR + LAMIVUDINE 1243
ABACAVIR + LAMIVUDINE + ZIDOVUDINE 1243
Abacavir/Lamivudine GH 600/300(GQ) *1243*
ABATACEPT 308, 310, 849, 1085
ABCIXIMAB 86
Abilify Maintena(LU) *625*
Abilify(OS) *625*
ABIRATERONE 303
Abisart HCT 150/12.5(AF) *126*
Abisart HCT 300/12.5(AF) *126*
Abisart HCT 300/25(AF) *126*
Abisart(AF) *123*
Abstral(FK) *754*, *755*, *756*
Abyraz (AF) *625*
ACAMPROSATE 659
ACARBOSE 67
Acarbose Mylan(AF) *67*
Accomin Adult Tonic(PF) *1557*
Accupril(PF) *117*
Accuretic 10/12.5mg(PF) *120*
Accuretic 20/12.5mg(PF) *120*
ACETAZOLAMIDE 683
Acetec(AL) *115*
ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID 1567
ACICLOVIR
.ANTIINFECTIVES FOR SYSTEMIC USE 229, 230
.SENSORY ORGANS 678
Aciclovir 200(CR) *229*
Aciclovir 800(CR) *230*
Aciclovir AN (ED) *229*
Aciclovir GH(GQ) *229*
Aciclovir Sandoz (HX) *229*, *230*
Aciclovir Sandoz(HX) *230*
Aci-Jel(CU) *1567*
Acimax Tablets(AL) *33*
ACITRETIN 164
Aclasta(HX) *569*, *570*
ACLIDINIUM 672
ACLIDINIUM + FORMOTEROL (EFORMOTEROL) 670
Aclor 125(QA) *210*
Aclor 250(QA) *210*
Acpio 15(RF) *69*
Acpio 30(RF) *69*
Acpio 45(RF) *69*
Acquin Aspen 10(RW) *117*
Acquin Aspen 20 (RW) *117*
Acquin Aspen 5 (RW) *117*
ACQUIN(RF) *117*
Acris Combi(AF) *573*, *1572*
Acris Once-a-Month(AF) *569*
Acris Once-a-Week(AF) *569*, *1571*
Actaze (RW) *69*
Actemra Subcutaneous Injection(RO) *530*, *533*
Actemra(RO) ..*934*, *941*, *946*, *951*, *1170*, *1171*, *1177*, *1183*, *1187*
Actiq(TB) *754*, *755*, *756*
Actisorb Plus MAP105(KI) *1584*
Actonel EC Combi D(UA) *574*, *1573*
Actonel EC Combi(UA) *573*, *1572*
Actonel EC(UA) *569*, *1571*
Actonel Once-a-Month (UA) *569*
Actonel(UA) *568*, *569*, *1571*
Actos(TK) *69*
Actrapid Penfill 3 mL(NO) *54*
Actrapid(NO) *54*
Acyclo-V 200(AF) *229*
Adalat 10(BN) *114*
Adalat 20(BN) *114*
Adalat Oros 20mg(BN) *114*
Adalat Oros 30(BN) *114*
Adalat Oros 60(BN) *114*
ADALIMUMAB324, 326, 327, 329, 332, 334, 336, 337, 339, 343, 346, 351, 353, 356, 358, 363, 367, 371, 374, 378, 381, 385, 875, 1112
ADAPALENE + BENZOYL PEROXIDE 174
Adaptic 2012(KI) *1596*
Adcirca(LY) *823*, *1058*
Addos XR 30(RW) *114*
Addos XR 60(RW) *114*
Adefin 10(AF) *114*
Adefin 20(AF) *114*
Adefin XL 30 (AF) *114*
Adefin XL 60 (AF) *114*
ADEFOVIR DIPIVOXIL 1236
Adempas(BN) *805*, *812*, *813*, *1040*, *1047*, *1048*
Adenuric(FK) *566*
Adesan HCT 16/12.5(AF) *124*
Adesan HCT 32/12.5(AF) *125*
Adesan HCT 32/25(AF) *125*
Adesan(AF) *122*
ADRENALINE
.CARDIOVASCULAR SYSTEM 102
.Prescriber Bag 18
.RESPIRATORY SYSTEM 674
ADT Booster(CS) *19*, *238*
ADVAGRAF XL(LQ) *555*, *956*, *957*, *1193*
Advantan(BN) *168*, *169*, *170*, *171*
Aeron 250(QA) *673*
Aeron 500(QA) *673*
Afinitor(NV) *257*, *258*
AFLIBERCEPT 689
Aggrastat(AS) *90*
Airomir Autohaler(IA) *666*
Akamin 50(AF) *200*
Akineton(GH) *609*
Akynzeo(MF) *38*
Albalon Liquifilm(AG) *1578*
Albalon-A(AG) *1578*
ALBENDAZOLE 663
Albey Bee Venom(DE) *707*
Albey Paper Wasp Venom(DE) *708*
Albey Yellow Jacket Venom(DE) *708*
Aldactone(PF) *108*
Aldara Pump(IA) *176*, *1566*
Aldara(IA) *176*, *1566*
Aldiq(QA) *176*, *1566*
Aldomet(AS) *105*
Alecensa(RO) *247*
ALECTINIB 246
ALEMTUZUMAB 854, 1090
Alendro Once Weekly(RW) *567*
Alendrobell 70mg(GQ) *567*
ALENDRONATE 567
ALENDRONATE + COLECALCIFEROL 570, 571, 1571
ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE 572, 1572
Alendronate Plus D3 Sandoz (SZ) *571*, *572*
Alendronate plus D3-DRLA(RZ) *571*, *572*, *1572*
Alendronate Sandoz (SZ) *567*
Alepam 15(AF) *633*, *759*
Alepam 30(AF) *633*, *759*
Alfamino Junior(NT) *728*, *730*
Alfamino(NT) *722*, *723*
Alfaré(NT) *726*
ALFUZOSIN 1568

Algisite M 66000519(SN) *1585*
Algisite M 66000520(SN) *1585*
Algisite M 66000521(SN) *1585*
Algivon Plus CR4225(DJ) *1586*
Algivon Plus Ribbon & Probe CR4231(DJ) *1586*
Alkeran(AS) *239*
Allegron(RW) *637*
Allereze(AF) *1578*
Allevyn 66007637(SN) *1587*
Allevyn Adhesive 66000044(SN) *1587*
Allevyn Ag Adhesive 66800073(SN) *1589*
Allevyn Ag Adhesive 66800075(SN) *1589*
Allevyn Ag Adhesive 66800078(SN) *1589*
Allevyn Ag Gentle Border 66800460(SN) *1589*
Allevyn Ag Gentle Border 66800461(SN) *1589*
Allevyn Ag Gentle Border 66800462(SN) *1589*
Allevyn Ag Non-Adhesive 66800086(SN) *1589*
Allevyn Gentle 66800248(SN) *1588*
Allevyn Gentle Border 66800269(SN) *1588*
Allevyn Gentle Border 66800270(SN) *1588*
Allevyn Life 66801067(SN) *1587*
Allevyn Life 66801068(SN) *1587*
Allevyn Life 66801069(SN) *1587*
Allevyn Life 66801070(SN) *1587*
Allevyn Thin 66047576(SN) *1591*
Allevyn Thin 66047578(SN) *1591*
Allmercap(LM) *241*
ALLOPURINOL 566
Allopurinol APOTEX(GX) *566*
Allopurinol Sandoz (SZ) *566*
Allosig(RF) *566*
Alodorm(AF)
.Palliative Care *760*
Alodorm(AF)
.NERVOUS SYSTEM *599*, *634*
ALOGLIPTIN 69
ALOGLIPTIN + METFORMIN 57
Aloxi(MF) *40*
Alpha Keri Bath Oil(MT) *1562*
Alpha Keri Lotion(MT) *1562*
AlphaClav Duo Forte(AF) *206*, *207*
AlphaClav Duo(AF) *206*, *207*
Alphagan P 1.5(AG) *682*
Alphagan(AG) *682*
Alphamox 125(AF) *201*
Alphamox 250(AF) *201*, *202*
Alphamox 500(AF) *201*
Alphapress 25(AF) *106*
Alphapress 50(AF) *106*
Alprax 0.25(QA) *632*
Alprax 0.5(QA) *631*
Alprax 1(QA) *631*
ALPRAZOLAM 631
Alprim(AF) *213*
ALPROSTADIL 1567
ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE 1554
Alvesco 160(AP) *672*
Alvesco 80(AP) *672*
Alzene(AF) *1578*
AMANTADINE 611
Amaryl(SW) *57*
AMBRISENTAN 772, 1007
AMCLAVOX DUO 500/125 (RW) *206*, *207*
AMCLAVOX DUO FORTE 875/125 (RW) *206*, *207*
Amdipharm Mercury (Australia) Pty Limited(GH)
.CARDIOVASCULAR SYSTEM *109*
.GENITO URINARY SYSTEM AND SEX HORMONES *188*
AMILORIDE + HYDROCHLOROTHIAZIDE 108
AMINO ACID FORMULA WITH CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE 733
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE WITHOUT PHENYLALANINE 733
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID 733
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID 733
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE 733
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE 734
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID 734
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS, TRACE ELEMENTS AND MEDIUM CHAIN TRIGLYCERIDES ...727, 728, 730, 731
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN 734
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE 734, 735
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE 735, 736
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE 736, 737
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE 737, 738
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE 738, 739
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE WITH FAT, CARBOHYDRATE AND TRACE ELEMENTS AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID 739
AMINO ACID FORMULA WITH VITAMINS AND MINERALS, LOW PHENYLALANINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID AND ARACHIDONIC ACID 739
AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE 739
AMINO ACID FORMULA WITHOUT PHENYLALANINE 740
AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE 740
AMINO ACID SYNTHETIC FORMULA 713, 714, 715
AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS 716, 717
AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES 718, 719, 720, 721, 722
AMIODARONE 101
Amiodarone Sandoz(SZ) *102*
Amipride 400(RW) *624*

Amira 150(AF) *641*
Amira 300(AF) *641*
AMISULPRIDE 624
Amisulpride 100 Winthrop(WA) *624*
Amisulpride 200 Winthrop(WA) *624*
Amisulpride 400 Winthrop (WA) *624*
Amisulpride AN (EA) *624*
Amisulpride AN(EA) *624*
Amisulpride Sandoz (SZ) *624*
Amisulpride Sandoz(SZ) *624*
AMITRIPTYLINE 635
Amitriptyline Alphapharm 10(AL) *635*
Amitriptyline Alphapharm 25(AL) *635*
Amitriptyline Alphapharm 50(AL) *635*
Amlo 10(RW) *113*
Amlo 5(RW) *113*
AMLODIPINE 113
AMLODIPINE + ATORVASTATIN 159
AMLODIPINE + VALSARTAN 128
AMLODIPINE + VALSARTAN + HYDROCHLOROTHIAZIDE 129
Amlodipine Amneal (EF) *113*
Amlodipine AN(EA) *113*
Amlodipine GH (GQ) *113*
Amlodipine Sandoz(SZ) *113*
AMMONIUM + SENEGA ROOT 1577
AMOROLFINE 1561
AMOXICILLIN 201, 202
AMOXICILLIN + CLAVULANIC ACID 206, 207
AMOXICLAV AMNEAL 500/125(ED) *206*, *207*
AMOXICLAV AMNEAL 875/125(ED) *206*, *207*
Amoxil Forte(AS) *202*
Amoxil(AS) *201*, *202*
Amoxycillin AN (EA) *201*
Amoxycillin generichealth 500(GQ) *201*
Amoxycillin Ranbaxy (RA) *201*
Amoxycillin Ranbaxy(RA) *201*
Amoxycillin Sandoz (SZ) *201*, *202*
Amoxycillin Sandoz(BG) *202*
Amoxycillin Sandoz(SZ) *201*
Amoxyclav AN 500/125 (EA) *206*, *207*
Amoxyclav AN 875/125 (EA) *206*, *207*
AmoxyClav generichealth 875/125(HQ) *206*, *207*
AMPHOTERICIN B 29
AMPICILLIN 202
Ampicyn(AF) *202*
Anafranil 25(SZ) *636*
ANAKINRA 928, 1164
Anamorph(RW) *580*, *582*
Anandron(SW) *302*
Anaprox 550(IX) *563*, *753*
Anastrol(QA) *302*
ANASTROZOLE 302
Anastrozole AN (EA) *302*
Anastrozole FBM(FO) *302*
Anastrozole GH (GQ) *302*
Anastrozole Sandoz(SZ) *302*
Andepra(EL) *642*
Andriol Testocaps(MK) *181*
Androcur(BN)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *187*
Androcur-100(BN)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*
Androderm(GN) *180*
AndroForte 5(LX) *180*
Anginine Stabilised(RW) *103*
Angiomax(XM) *90*
Anoro Ellipta 62.5/25(GK) *671*
Anpec 40(AF) *114*
Anpec 80(AF) *114*
Antenex 2(AF) *632*, *759*
Antenex 5(AF) *632*, *759*
ANTERONE 100(RW)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*
ANTERONE 50(RW)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
Anthel 125(AF) *664*
Anthel 250(AF) *664*
Antroquoril(FR) *167*
Anusol(JT) *1560*
Apidra SoloStar (SW) *54*
Apidra(AV) *54*
Apidra(SW) *54*
APIXABAN 92, 93, 94
APO- Hydroxychloroquine(TX) *564*
APO- Paracetamol/Codeine 500/30(TX) *589*
APO-Adefovir(TX) *1237*
APO-Alendronate (TX) *567*
APO-Alendronate Plus D3 70 mg/140 mcg (TX) *1572*
APO-Alendronate Plus D3 70 mg/140 mcg(TX) *571*
APO-Alendronate Plus D3 70 mg/70 mcg (TX) *1572*
APO-Alendronate Plus D3 70 mg/70 mcg(TX) *572*
APO-Alendronate Plus D3 and Calcium(TX) *1572*
APO-Allopurinol (TX) *566*
APO-Amiodarone (TX) *102*
APO-Amisulpride (TX) *624*
APO-Amisulpride(TX) *624*
APO-Amitriptyline 10 (TX) *635*
APO-Amitriptyline 25 (TX) *635*
APO-Amitriptyline 50 (TX) *635*
APO-Amlodipine (TX) *113*
APO-Amlodipine/Atorvastatin 10/10(TX) *160*
APO-Amlodipine/Atorvastatin 10/20(TX) *160*
APO-Amlodipine/Atorvastatin 10/40(TX) *161*
APO-Amlodipine/Atorvastatin 10/80(TX) *160*
APO-Amlodipine/Atorvastatin 5/10(TX) *160*
APO-Amlodipine/Atorvastatin 5/20(TX) *160*
APO-Amlodipine/Atorvastatin 5/40(TX) *160*
APO-Amlodipine/Atorvastatin 5/80(TX) *160*
APO-Amoxycillin (TX) *201*
APO-Amoxycillin and Clavulanic Acid (TX) *206*, *207*
APO-Amoxycillin and Clavulanic Acid 125/31.25(TX) *207*
APO-Amoxycillin and Clavulanic Acid 400/57(TX) *206*, *207*
APO-Amoxycillin(TX) *201*, *202*
APO-Amoxycillin/ Clavulanic Acid 500/125(TX) *206*, *207*
APO-Anastrozole (TX) *302*
APO-Aripiprazole(TX) *625*
APO-Atenolol(TX) *110*
APO-Atomoxetine(TX) *646*
APO-Atorvastatin(TX) *131*, *132*
APO-Azathioprine(TX) *556*
APO-Azithromycin(TX)
.Repatriation Pharmaceutical Benefits Scheme *1570*
APO-Azithromycin(TX)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*
APO-Baclofen(TX) *565*
APO-Bicalutamide(TX) *300*

APO-Bisoprolol(TX) *110*
APOC-5FU(TX) *1570*
APO-Cabergoline(TX) *177*, *178*
APO-Calcitriol(TX)
.ALIMENTARY TRACT AND METABOLISM *79*
.MUSCULO-SKELETAL SYSTEM *574*
APO-Candesartan (TX) *122*
APO-Candesartan HCTZ 16/12.5 (TX) *124*
APO-Candesartan HCTZ 32/12.5 (TX) *125*
APO-Candesartan HCTZ 32/25 (TX) *125*
APO-Carvedilol(TX) *112*
APO-Cefaclor (TX) *210*
APO-Cefaclor CD(TX) *210*
APO-Celecoxib(TX) *564*
APO-Cephalexin(TX) *207*, *208*
APO-Ciprofloxacin(TX) *219*, *220*
APO-Citalopram(TX) *637*
APO-Clarithromycin(TX) *214*, *830*, *1065*
APO-Clindamycin(TX) *216*, *217*
APO-Clonidine(TX) *105*
APO-Clopidogrel(TX) *87*, *1559*
APO-Clopidogrel/Aspirin 75/100(TX) *88*
APO-Clotrimazole 3 Day Cream(TX) *1566*
APO-Clotrimazole 6 Day Cream(TX) *1567*
APO-Desvenlafaxine MR(TX) *641*, *642*
APO-Diazepam (TX) *632*, *759*
APO-Diazepam(TX) *632*, *759*
APO-Diclofenac(TX) *558*, *559*, *751*
APO-Donepezil(TX) *650*, *651*
APO-Dorzolamide(TX) *684*
APO-Dorzolamide/Timolol 20/5(TX) *685*
APO-Doxycycline(TX) *198*, *199*, *200*
APO-Duloxetine (TX) *642*
APO-Dutasteride(TX) *189*
APO-Enalapril (TX) *115*
APO-Escitalopram(TX) *637*, *638*
APO-Exemestane(TX) *302*, *303*
APO-Famciclovir(TX) *230*, *231*, *232*
APO-Fentanyl(TX) *586*, *587*, *588*
APO-Finasteride(TX) *1569*
APO-Flucloxacillin(TX) *205*, *206*
APO-Fluconazole(TX) *223*
APO-Fluoxetine(TX) *639*
APO-Fluvoxamine(TX) *639*, *640*
APO-Fosinopril HCTZ 20/12.5(TX) *119*
APO-Fosinopril(TX) *116*
APO-Frusemide(TX) *107*
APO-Gabapentin(TX)
.Repatriation Pharmaceutical Benefits Scheme *1574*
APO-Gabapentin(TX)
.NERVOUS SYSTEM *602*
APO-Galantamine MR(TX) *651*, *652*
APO-Gliclazide MR(TX) *56*
APO-Glimepiride(TX) *57*
APOHEALTH Osteo Relief Paracetamol 665 mg(TX) .. *594*, *758*
APO-Ibuprofen 400(TX) *561*, *752*
APO-Imiquimod (TX) *176*, *1566*
APO-Indapamide SR(TX) *107*
APO-Ipratropium (TX) *673*
APO-Irbesartan (TX) *123*
APO-Irbesartan HCTZ (TX) *126*
APO-Isotretinoin(TX) *174*, *175*
APO-Itraconazole(TX) *225*
APO-Lamotrigine(TX) *605*
APO-Lansoprazole ODT(TX) *32*
APO-Lansoprazole(TX) *32*
APO-Latanoprost(TX) *687*
APO-Latanoprost/Timolol 0.05/5(TX) *687*, *688*
APO-Lercanidipine(TX) *113*
APO-Letrozole(TX) *303*
APO-Levetiracetam(TX) *605*, *606*
APO-Lisinopril(TX) *116*
APO-MACROGOL plus ELECTROLYTES(TX) *46*, *750*
APO-Meloxicam(TX) *560*
APO-Memantine(TX) *655*, *656*
APO-Metformin 1000(TX) *56*
APO-Metformin 500(TX) *56*
APO-Metformin 850(TX) *56*
APO-Metformin XR 1000(TX) *55*
APO-Metformin XR 500(TX) *56*
APO-Metoclopramide(TX) *36*
APO-Metoprolol(TX) *111*
Apomine Solution for Infusion(PF) *969*, *1206*
APO-Mirtazapine(TX) *643*
APO-Modafinil(TX) *649*
APO-Montelukast(TX) *676*
APOMORPHINE 969, 1206
APO-Mycophenolate(TX) ... *316*, *317*, *863*, *864*, *1099*, *1100*
APO-Naltrexone(TX) *660*
APO-Nifedipine XR(TX) *114*
APO-Olanzapine ODT(TX) *620*, *621*, *622*
APO-Olanzapine(TX) *619*, *620*
APO-Olmesartan(TX) *123*, *124*
APO-Olmesartan/Amlodipine 20/5(TX) *128*
APO-Olmesartan/Amlodipine 40/10(TX) *129*
APO-Olmesartan/Amlodipine 40/5(TX) *129*
APO-Olmesartan/HCTZ 20/12.5(TX) *126*
APO-Olmesartan/HCTZ 40/12.5(TX) *126*
APO-Olmesartan/HCTZ 40/25(TX) *126*
APO-Omeprazole(TX) *33*, *34*
APO-Ondansetron(TX) *38*, *39*
APO-Oxazepam (TX) *633*, *759*
APO-Pantoprazole(TX) *34*
APO-Paracetamol(TX) *593*, *1573*, *1574*
APO-Paroxetine(TX) *640*
APO-Perindopril Arginine(TX) *116*, *117*
APO-Perindopril Arginine/Amlodipine 10/10(TX) *121*
APO-Perindopril Arginine/Amlodipine 10/5(TX) *121*
APO-Perindopril Arginine/Amlodipine 5/10(TX) *121*
APO-Perindopril Arginine/Amlodipine 5/5(TX) *121*
APO-Perindopril(TX) *116*, *117*
APO-Pramipexole ER(TX) *613*
APO-Pramipexole(TX) *612*, *613*
APO-Pravastatin(TX) *133*, *134*
APO-Prazosin(TX) *106*
APO-Pregabalin(TX) *594*
APO-Prochlorperazine(TX) *42*
APO-Propranolol(TX) *109*
APO-Quetiapine XR(TX) *622*, *623*
APO-Quetiapine(TX) *623*, *624*
APO-Quinapril (TX) *117*
APO-Quinapril(TX) *117*
APO-Rabeprazole(TX) *35*
APO-Raloxifene(TX) *575*
APO-Ramipril(TX) *117*, *118*
APO-Ranitidine(TX) *30*
APO-Riluzole(TX) *661*
APO-Risedronate (TX) *569*, *1571*
APO-Risedronate(TX) *569*
APO-Risperidone(TX) *627*, *628*, *629*, *630*, *631*
APO-Rizatriptan(TX) *596*
APO-Rosuvastatin(TX) *134*, *135*, *136*, *137*
APO-Roxithromycin(TX) *216*
Aporyl(TX) *1561*
APO-Salbutamol(TX) *22*, *666*
APO-Sertraline(TX) *640*
APO-Sildenafil PHT(TX) *818*, *1053*
APO-Sildenafil(TX) *1567*, *1568*
APO-Simvastatin(TX) *137*, *138*, *139*

APO-Sotalol(TX) *102*
APO-Sumatriptan(TX) *596*, *597*
APO-Telmisartan HCTZ 40/12.5(TX) *127*
APO-Telmisartan HCTZ 80/12.5(TX) *127*
APO-Telmisartan HCTZ 80/25(TX) *127*
APO-Telmisartan(TX) *124*
APO-Temazepam(TX) *634*, *635*, *760*
APO-Temozolomide(TX) *239*, *240*
APO-Terbinafine(TX) *162*, *163*
APOTEX-Pantoprazole (GX) *34*
APOTEX-Pioglitazone (TX) *69*
APO-Topiramate(TX) *607*, *608*
APO-Tramadol SR(TX) *591*
APO-Tramadol(TX) *591*, *592*
APO-Tranexamic Acid(TX) *98*
APO-Ursodeoxycholic acid(TX) *43*
APO-Valaciclovir(TX) *233*, *234*, *831*, *1067*
APO-Valsartan HCTZ 160/12.5(TX) *127*
APO-Valsartan HCTZ 160/25(TX) *127*
APO-Valsartan HCTZ 320/12.5(TX) *128*
APO-Valsartan HCTZ 320/25(TX) *128*
APO-Valsartan HCTZ 80/12.5(TX) *127*
APO-Valsartan(TX) *124*
APO-Venlafaxine XR(TX) *644*
APO-Ziprasidone(TX) *617*
APO-Zoledronic Acid(TX) *969*, *1205*
APO-Zolmitriptan(TX) *597*
APO-Zonisamide(TX) *609*
APO-Zopiclone(TX) *1575*
APRACLONIDINE 682
APREPITANT 41
Aptamil Gold+ De-Lact(NU) *732*
Aptamil Gold+ Pepti-Junior(NU) *724*
Aptivus(BY) *1236*
Aquacare H.P.(AG) *1562*
Aquacel 403770(CC) *1593*
Aquacel Ag 403708(CC) *1594*
Aquacel Ag 403710(CC) *1594*
Aquacel Ag 403771(CC) *1594*
Aquacel Extra 420672(CC) *1593*
Aquacel Extra 420673(CC) *1593*
Aquacel Foam Adhesive(CC) *1593*
Aquacel Foam Non-Adhesive(CC) *1593*
Aquasun Lotion SPF 18(PF) *1562*
Arabloc(AV) *316*
ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE 740
Aranesp SureClick(AN) *769*, *1004*
Aranesp(AN) *769*, *770*, *1004*, *1005*
Aratac 100(AF) *102*
Aratac 200(AF) *102*
Arava (SW) *316*
Arazil (AF) *650*, *651*
ARDIX GLICLAZIDE 60mg MR(RX) *57*
Arginaid Extra(NT) *1579*
Arginaid(NT) *1579*
Arginine 2000(VF) *740*
Arginine 500(VF) *740*
Arginine 5000(VF) *740*
ARGININE WITH CARBOHYDRATE 740
Arianna 1(AF) *302*
Aricept(PF) *650*, *651*
Aridon 10(RW) *650*, *651*
Aridon 5(RW) *650*, *651*
Aridon APN 10 (RF) *650*, *651*
Aridon APN 5 (RF) *650*, *651*
Arimidex (AP) *302*
ARIPIPRAZOLE 625
Aripiprazole AN (EA) *625*
Aripiprazole GH(GQ) *625*
Aripiprazole Sandoz (SZ) *625*
Aristocort 0.02%(QA) *165*
Arixtra(AS) *97*
ARMODAFINIL 644
Aromasin(PF) *302*, *303*
Aropax(AS) *640*
Arrow Pharma Pty Ltd(RW) *228*
Artane(RW) *609*
ARTEMETHER + LUMEFANTRINE 662, 663
Arthrexin(AF) *559*, *752*
Artige(NM) *648*
Asacol(EU) *50*
Asartan HCT 16/12.5(DO) *125*
Asartan HCT 32/12.5(DO) *125*
Asartan HCT 32/25(DO) *125*
Asasantin SR(BY) *89*
ASENAPINE 618
Asmol 2.5 uni-dose(AF) *22*, *666*
Asmol 5 uni-dose(AF) *22*, *666*
Asmol CFC-free(AL) *22*, *665*
Aspalgin 40(QA) *1573*
Aspecillin VK(QA) *203*, *204*
Aspen Methadone Syrup(QA)
.Opiate Dependence Treatment Program *1544*
.Palliative Care *757*
Aspen Pharma Pty Ltd(QA) *647*
ASPIRIN
.BLOOD AND BLOOD FORMING ORGANS 86
.NERVOUS SYSTEM 592
.Repatriation Pharmaceutical Benefits Scheme 1558
ASPIRIN + CODEINE 1573
Astrix(YN) *1558*
Astzol(JU) *302*
Atacand Plus 16/12.5(AP) *125*
Atacand Plus 32/12.5(AP) *125*
Atacand Plus 32/25(AP) *125*
Atacand(AP) *122*
Ataris 10(AF) *316*
Ataris 20(AF) *316*
ATAZANAVIR 1233
ATAZANAVIR + COBICISTAT 1233
ATELVIA ONCE-A-MONTH (GN) *569*
ATENOLOL 110
Atenolol Amneal (EF) *110*
Atenolol GH (GQ) *110*
Atenolol Sandoz(SZ) *110*
Atenolol-AFT(AE) *110*
Atenolol-GA(ED) *110*
ATOMERRA (RW) *646*
ATOMOXETINE 645, 646
Atomoxetine Amneal(EA) *646*
Atomoxetine Sandoz (SZ) *646*
ATORVASTATIN 131
Atorvastatin Amneal (EF) *131*, *132*
Atorvastatin GH(GQ) *131*, *132*
Atorvastatin Sandoz (SZ) *131*, *132*
Atorvastatin SCP 10(RZ) *131*, *132*
Atorvastatin SCP 20(RZ) *131*, *132*
Atorvastatin SCP 40(RZ) *131*, *132*
Atorvastatin SCP 80(RZ) *131*, *132*
Atorvastatin SZ (HX) *131*, *132*
ATOVAQUONE 662
ATOVAQUONE + PROGUANIL 662
Atozet(MK) *147*, *149*
Atrauman 499513(HR) *1595*
Atrauman Ag 499572(HR) *1596*
Atripla(GI) *1247*
ATROPINE SULFATE MONOHYDRATE
.ALIMENTARY TRACT AND METABOLISM 36
.Prescriber Bag 18

.SENSORY ORGANS 689
Atropt(QA) *689*
Atrovent Adult(BY) *673*
Atrovent Nasal Aqueous(VZ) *1577*
Atrovent Nasal Forte(VZ) *1577*
Atrovent(BY) *673*
Aubagio(GZ) *318*
Augmentin Duo 400(AS) *206*, *207*
Augmentin Duo forte(AS) *206*, *207*
Augmentin Duo(AS) *206*, *207*
AURANOFIN 564
Auro-Amlodipine 10(DO) *113*
Auro-Amlodipine 5(DO) *113*
Auro-Candesartan 16(DO) *122*
Auro-Candesartan 32(DO) *122*
Auro-Candesartan 4(DO) *122*
Auro-Candesartan 8(DO) *122*
Auro-Citalopram 20 (DO) *637*
Auro-Citalopram 40 (DO) *637*
Auro-Famciclovir 125 (DO) *231*
Auro-Famciclovir 250 (DO) *230*, *231*
Auro-Famciclovir 500 (DO) *231*, *232*
Auro-Finasteride(DO) *1569*
Auro-Lisinopril 10 (DO) *116*
Auro-Lisinopril 20 (DO) *116*
Auro-Lisinopril 5 (DO) *116*
Auro-Montelukast Tabs 4 (DO) *676*
Auro-Montelukast Tabs 5 (DO) *676*
Auro-Pravastatin 10 (DO) *133*
Auro-Pravastatin 20 (DO) *133*
Auro-Pravastatin 40 (DO) *133*, *134*
Auro-Pravastatin 80 (DO) *133*, *134*
Aurorix 300 mg(HM) *641*
Aurorix(HM) *641*
Auro-Sertraline 100 (DO) *640*
Auro-Sertraline 100(DO) *640*
Auro-Sertraline 50 (DO) *640*
Auro-Sertraline 50(DO) *640*
Auro-Simvastatin 10 (DO) *138*, *139*
Auro-Simvastatin 20 (DO) *138*, *139*
Auro-Simvastatin 40 (DO) *138*, *139*
Auro-Simvastatin 80 (DO) *137*, *138*
Aurozapine 30 (DO) *643*
Aurozapine 45 (DO) *643*
Auscap Aspen (RW) *639*
Ausfam 20(RW) *29*
Ausfam 40(RW) *29*
Ausgem(RW) *140*
Ausran (RW) *30*
Austrapen (AL) *202*
Austrapen(AL) *202*
Avandamet(GK) *63*, *64*
Avanza SolTab(MK) *643*
Avanza(MK) *643*
Avapro HCT 150/12.5(AV) *126*
Avapro HCT 300/12.5(AV) *126*
Avapro HCT 300/25(AV) *126*
Avapro(AV) *123*
Avodart (GK) *189*
Avodart(GK) *1569*
Avonex(BD) *305*
Axit 15 (AF) *643*
Axit 30(AF) *643*
Axit 45(AF) *643*
AXITINIB 247
Aylide 1 (AF) *57*
Aylide 2 (AF) *57*
Aylide 3 (AF) *57*
Aylide 4 (AF) *57*
AZACITIDINE 836, 837, 1071, 1072
Azacitidine Accord(OC) *837*, *1072*
AZACITIDINE DR.REDDY'S (RI) *837*, *1072*
Azadine(RZ) *837*, *1072*
Azapin (RW) *556*
Azarga(NV) *684*
Azastrole (ER) *302*
AZATHIOPRINE 556
Azathioprine AN(EA) *556*
Azathioprine GH (GQ) *556*
Azathioprine Sandoz(SZ) *556*
Azilect(TB) *614*
AZITHROMYCIN
.ANTIINFECTIVES FOR SYSTEMIC USE 214
.Highly Specialised Drugs Program (Private Hospital) 829
.Highly Specialised Drugs Program (Public Hospital) 1065
.Repatriation Pharmaceutical Benefits Scheme 1570
.SENSORY ORGANS 677
Azithromycin Mylan (AF) *214*, *677*
Azithromycin Mylan(AF)
.Repatriation Pharmaceutical Benefits Scheme *1570*
Azithromycin Sandoz (SZ)
.Repatriation Pharmaceutical Benefits Scheme *1570*
Azithromycin Sandoz(SZ)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*
Azithromycin-GA (EA) *1570*
Azol 100(AF) *187*
Azol 200(AF) *187*
Azopt(NV) *683*
BACLOFEN 565, 967, 1203, 1204
Bacthecal(DZ) *968*, *1204*
Bactigras 7457(SN) *1590*
Bactrim DS(RO) *213*, *214*
Bactrim(RO) *213*
Bactroban(GK)
.Repatriation Pharmaceutical Benefits Scheme *1563*
Bactroban(GK)
.RESPIRATORY SYSTEM *665*
BALSALAZIDE 49
BANDAGE ABSORBENT WOOL 1580
BANDAGE CALICO 1580
BANDAGE COMPRESSION 1580
BANDAGE RETENTION COHESIVE HEAVY 1581
BANDAGE RETENTION COHESIVE LIGHT 1581
BANDAGE RETENTION COTTON CREPE 1581
BANDAGE TUBULAR 1582
BANDAGE TUBULAR FINGER 1582
BANDAGE TUBULAR LIGHT WEIGHT 1582
BANDAGE TUBULAR LONG STOCKING 1583
BANDAGE TUBULAR SHORT STOCKING 1583
BANDAGE ZINC PASTE 1583
Baraclude(BQ) *1238*
Barbloc 5(AF) *109*
basecal 100(VF) *741*
basecal 200(VF) *741*
Baxter Healthcare Pty Ltd(BX) *1560*
BECLOMETASONE 671
Bemfola(FX) *185*, *1538*
BenPen(CS) *18*, *202*, *203*
BENZATHINE BENZYLPENICILLIN 202
BENZATROPINE 18, 609
BENZHEXOL 609
Benztrop(PL) *609*
Benztropine Omega(FK) *18*, *609*
BENZYDAMINE 29, 749
BENZYLPENICILLIN 18, 202
Beprol 10 (DO) *110*
Beprol 2.5 (DO) *110*
Beprol 5 (DO) *110*
Betadine Antiseptic Liquid(SW) *1564*

Betaferon(BN) *306*
BETAINE 81
BETAINE + POLYAMINOPROPYL BIGUANIDE 1584
Betaloc(AP) *111*
BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE 192
BETAMETHASONE DIPROPIONATE 165, 166
BETAMETHASONE VALERATE 167, 168, 1564
betaquik(VF) *712*
Betavit(PP) *79*, *1557*
BETAXOLOL 685
BETHANECHOL 656
Betnovate 1/2(QA) *167*, *168*
Betnovate 1/5(QA) *167*
Betnovate(QA) *1564*
Betoptic S(NV) *685*
Betoptic(NV) *685*
BetoQuin(NM) *685*
Bi ELIGARD CP(TL)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *298*, *301*, *302*
Biatain Adhesive 3420(CT) *1591*
Biatain Adhesive 3423(CT) *1591*
Biatain Ag 9622(CT) *1596*
Biatain Ag 9632(CT) *1596*
Biatain Non-adhesive 3410(CT) *1591*
Biatain Non-adhesive 3413(CT) *1591*
Biaxsig (AV) *216*
Bicalide (JU) *300*
Bicalox(ER) *300*
BICALUTAMIDE 300
Bicalutamide AN (EA) *300*
BICARBONATE 188
BICARBONATE + CITRIC ACID + TARTARIC ACID .. 1568
Bicard 10(RW) *110*
Bicard 2.5(RW) *110*
Bicard 5(RW) *110*
Bicillin L-A(PF) *202*
Bicor(AL) *110*
Biltricide(BN) *663*
BIMATOPROST 686
BIMATOPROST + TIMOLOL 686, 687
Bimatoprost Sandoz(SZ) *686*
Bimtop (QA) *686*
Biodone Forte (MW) *1544*
Bion Tears(NV) *701*
BIPERIDEN 609
BISACODYL
.ALIMENTARY TRACT AND METABOLISM ... 43, 44, 46
.Palliative Care 749, 750
.Repatriation Pharmaceutical Benefits Scheme 1555
Bisalax(AS) *46*, *751*
BISOPROLOL 110
Bisoprolol AN (EA) *110*
Bisoprolol generichealth(GQ) *110*
Bisoprolol Sandoz (SZ) *110*
Bispro 10(AF) *110*
Bispro 2.5(AF) *110*
Bispro 5(AF) *110*
BIVALIRUDIN 90
Bivalirudin APOTEX (TX) *90*
Blooms the Chemist Amlodipine (IB) *113*
Blooms the Chemist Amlodipine/Atorvastatin 10/10 (IB) *160*
Blooms the Chemist Amlodipine/Atorvastatin 10/20 (IB) *160*
Blooms the Chemist Amlodipine/Atorvastatin 10/40 (IB) *161*
Blooms the Chemist Amlodipine/Atorvastatin 10/80 (IB) *160*
Blooms the Chemist Amlodipine/Atorvastatin 5/10 (IB) . 160
Blooms the Chemist Amlodipine/Atorvastatin 5/20 (IB) . 160
Blooms the Chemist Amlodipine/Atorvastatin 5/40 (IB) . 160
Blooms the Chemist Amlodipine/Atorvastatin 5/80 (IB) . 160
Blooms the Chemist Atorvastatin(IB) *131*, *132*
Blooms the Chemist Candesartan (IB) *122*
Blooms the Chemist Candesartan HCTZ 16/12.5 (IB) *125*
Blooms the Chemist Candesartan HCTZ 32/12.5 (IB) *125*
Blooms the Chemist Candesartan HCTZ 32/25 (IB) *125*
Blooms the Chemist Celecoxib (IB) *564*
Blooms the Chemist Clopidogrel (IB) *87*, *1559*
Blooms the Chemist Escitalopram (IB) *637*, *638*
Blooms the Chemist Fluoxetine(IB) *639*
Blooms the Chemist Irbesartan HCTZ 150/12.5(IB) *126*
Blooms the Chemist Irbesartan HCTZ 300/12.5(IB) *126*
Blooms the Chemist Irbesartan HCTZ 300/25(IB) *126*
Blooms the Chemist Irbesartan(IB) *123*
Blooms the Chemist Lercanidipine (IB) *113*
Blooms the Chemist Metformin XR 1000 (IB) *55*
Blooms the Chemist Metformin XR 500 (IB) *56*
Blooms the Chemist Perindopril (IB) *116*, *117*
Blooms The Chemist Pregabalin (IB) *594*
Blooms the Chemist Rosuvastatin (IB) ... *134*, *135*, *136*, *137*
Blooms the Chemist Venlafaxine XR (IB) *644*
Bondronat(RO) *568*, *968*, *1204*
Bonefos 800 mg(BN) *568*
Bonefos(BN) *568*
BOSENTAN 777, 782, 1012, 1018
Bosentan APOTEX(TX) *782*, *788*, *1017*, *1023*
Bosentan GH(GQ) *782*, *1017*
Bosentan Mylan (AF) *782*, *1017*
Bosentan Mylan(AF) *788*, *1023*
Bosentan RBX (RA) *788*, *1023*
Bosentan RBX(RA) *782*, *1018*
Bosentan Sandoz (SZ) *782*, *1018*
Bosentan Sandoz(SZ) *788*, *1023*
BOSENTAN-DRLA (RZ) *782*, *788*, *1017*, *1023*
BOSLEER (RW) *788*, *1023*
BOSLEER(RW) *782*, *1018*
Botox(AG) *1254*, *1255*, *1256*, *1257*
BOTULINUM TOXIN TYPE A 1254, 1255, 1256
Brenzys(MK) .. *412*, *414*, *415*, *418*, *434*, *435*, *437*, *439*, *446*, *450*, *454*, *457*, *474*
Breo Ellipta 100/25(GK) *670*
Breo Ellipta 200/25(GK) *670*
Bretaris Genuair(FK) *673*
Brevinor(PF) *178*
Brevinor-1(PF) *178*
BREXPIPRAZOLE 625
Bricanyl Turbuhaler(AP) *666*
Bricanyl(AP) *675*
Brilinta(AP) *89*
Brimica Genuair(FK) *670*
BRIMONIDINE 682
BRIMONIDINE + TIMOLOL 682
BRINZOLAMIDE 683
BRINZOLAMIDE + BRIMONIDINE 684
BRINZOLAMIDE + TIMOLOL 684
BrinzoQuin(NM) *683*
BROMAZEPAM 1574
BROMOCRIPTINE
.GENITO URINARY SYSTEM AND SEX HORMONES 176, 177
.NERVOUS SYSTEM 612
bronchitol(XA) *989*, *1225*
Brufen (GO) *561*, *752*
BSN 2902165(BV) *1597*
Budamax Aqueous(PM) *1577*
Budenofalk(OA) *49*
BUDESONIDE
.ALIMENTARY TRACT AND METABOLISM 49
.Repatriation Pharmaceutical Benefits Scheme 1577
.RESPIRATORY SYSTEM 671, 672

BUDESONIDE + FORMOTEROL (EFORMOTEROL).. 667, 668
BUPRENORPHINE
.NERVOUS SYSTEM..... 588
.Opiate Dependence Treatment Program 1543
.Palliative Care 757
BUPRENORPHINE + NALOXONE..... 1543
BUPROPION 656, 657
Buscopan(VZ)..... *19*, *749*, *1554*
Buspar(QA)..... *1575*
BUSPIRONE..... 1575
BUSULFAN..... 239
Butamol 2.5 (QA) *22*, *666*
Butamol 5 (QA)..... *22*, *666*
Bydureon(AP) *75*
Byetta 10 microgram(AP)..... *76*
Byetta 5 microgram(AP)..... *76*
Cabaser(PF) *612*
CABERGOLINE
.GENITO URINARY SYSTEM AND SEX HORMONES 177
.NERVOUS SYSTEM..... 612
CADEXOMER-IODINE 1584
Cadivast 10/10(AF)..... *160*
Cadivast 10/20(AF)..... *160*
Cadivast 10/40(AF)..... *161*
Cadivast 10/80(AF)..... *160*
Cadivast 5/10(AF)..... *160*
Cadivast 5/20(AF)..... *160*
Cadivast 5/40(AF)..... *160*
Cadivast 5/80(AF)..... *160*
Caduet 10/10(PF) *160*
Caduet 10/20(PF) *160*
Caduet 10/40(PF) *161*
Caduet 10/80(PF) *160*
Caduet 5/10(PF) *160*
Caduet 5/20(PF) *160*
Caduet 5/40(PF) *160*
Caduet 5/80(PF) *160*
Caelyx(JC) *838*, *1073*
Cal-500(PP) *80*, *1558*
CAL-600(PP) *1558*
CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE 163
Calcipotriol/Betamethasone Sandoz 50/500(SZ) *163*
Calciprox (ER) *79*, *574*
Calci-Tab 600(AE) *80*
CALCITONIN SALMON (SALCATONIN)..... 198
CALCITRIOL
.ALIMENTARY TRACT AND METABOLISM 79
.MUSCULO-SKELETAL SYSTEM 574
Calcitriol AN(EA)
.ALIMENTARY TRACT AND METABOLISM *79*
.MUSCULO-SKELETAL SYSTEM *574*
CALCIUM..... 80, 1557, 1558
CALCIUM CARBONATE + GLYCINE..... 1554
Calcium Folinate Ebewe(SZ) *709*, *710*
Calindamin (RW) *216*, *217*
Calmurid(OL) *1562*
Calutex(QA) *300*
Camino Pro Bettermilk(QH) *742*
Camino Pro Complete(QH)..... *742*
Campral(AF) *660*
CANDESAN COMBI 16/12.5(RF) *125*
CANDESAN COMBI 32/12.5(RF) *125*
CANDESAN COMBI 32/25(RF) *125*
CANDESAN(RF)..... *122*
CANDESARTAN..... 122
CANDESARTAN + HYDROCHLOROTHIAZIDE 124
Candesartan AN (EA) *122*
Candesartan Aspen 16(RW) *122*
Candesartan Aspen 32(RW) *122*
Candesartan Aspen 4(RW) *122*
Candesartan Aspen 8(RW) *122*
Candesartan Combi Aspen 16/12.5 (RW) *125*
Candesartan Combi Aspen 32/12.5 (RW) *125*
Candesartan Combi Aspen 32/25 (RW) *125*
Candesartan GH (GQ)..... *122*
Candesartan HCT GH 16/12.5(GQ) *125*
Candesartan HCT GH 32/12.5(GQ) *125*
Candesartan HCT GH 32/25(GQ) *125*
Candesartan HCTZ AN 16/12.5(EA) *125*
Candesartan HCTZ AN 32/12.5(EA) *125*
Candesartan HCTZ AN 32/25(EA) *125*
Candesartan Sandoz (SZ)..... *122*
Candesartan Sandoz(SZ)..... *122*
Candesartan/HCT Sandoz (SZ) *125*
CAPECITABINE 241
Capecitabine Alphapharm(AF) *242*
Capecitabine AN (EA) *242*
Capecitabine AN(EA) *241*
Capecitabine Apotex(TX) *242*
Capecitabine MYX(OC)..... *241*, *242*
Capecitabine Sandoz (SZ) *242*
Capecitabine-DRLA (RZ)..... *241*, *242*
Capoten(RW) *115*
CAPTOPRIL 115
Captopril Sandoz(SZ) *115*
Carafate(AS) *35*
CARBAMAZEPINE..... 599, 600
Carbamazepine Sandoz(SZ) *599*, *600*
CARBAMIDE PEROXIDE..... 1579
Carbimazol ARISTO(PQ) *197*
CARBIMAZOLE..... 196
CarboFLEX 403202(CC) *1584*
CarboFLEX 403204(CC) *1584*
Carbohydrate Free Mixture(SB) *744*
CARBOHYDRATE, FAT, VITAMINS, MINERALS AND TRACE ELEMENTS 740
CARBOHYDRATES, FAT, VITAMINS, MINERALS, TRACE ELEMENTS AND SUPPLEMENTED WITH ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID 741
CARBOMER-974 698
CARBOMER-980 ..... 698, 699
carbzero(VF) *713*
Cardasa(AF)..... *1558*
Cardiprin 100(RC) *1558*
Cardizem CD(SW)..... *114*, *115*
Cardizem(SW)..... *114*
Cardol (AF)..... *102*
CARMELLOSE SODIUM..... 699, 700
CARMELLOSE SODIUM + GELATIN + PECTIN 1562
CARMELLOSE SODIUM + GLYCEROL 700, 701
CARMUSTINE..... 239
Cartia(AS)..... *1559*
CARVEDILOL..... 112
Carvedilol AN (EA) *112*
Carvedilol Sandoz(SZ) *112*
Catapres 100 (BY)..... *105*
Catapres(BY)..... *105*
Caverject Impulse(PF)..... *1567*
Cavicare 4563(SN)..... *1587*
Cavstat(AF) *134*, *135*, *136*, *137*
Ceclor CD(AS)..... *210*
Ceclor(AS)..... *210*
CEFACLOR..... 210
Cefaclor GH (GQ)..... *210*
CEFALEXIN 207, 208
Cefalexin Sandoz (SZ) *207*, *208*

Cefalexin Sandoz(SZ) *208*
CEFAZOLIN 208, 209
Cefazolin Sandoz(SZ) *209*
Cefazolin-AFT(AE) *208*, *209*
CEFEPIME 212
Cefepime Alphapharm (AF) *212*, *213*
Cefepime Kabi(PK) *212*, *213*
Cefepime-AFT(AE) *212*, *213*
CEFOTAXIME 211
CEFTRIAXONE 211, 212
Ceftriaxone Alphapharm(AF) *212*
Ceftriaxone Sandoz (SZ) *212*
Ceftriaxone-AFT(AE) *211*, *212*
CEFUROXIME 210
Celapram(AF) *637*
Celaxib(AF) *564*
Celazadine (JU) *837*, *1072*
Celebrex (PF) *564*
CELECOXIB 564
Celecoxib AN(EA) *564*
Celecoxib GH (GQ) *564*
Celecoxib RBX(RA) *564*
Celecoxib Sandoz (SZ) *564*
Celestone Chronodose(MK) *192*
Celestone-M(MK) *167*
Celexi(RW) *564*
Celica (RA) *637*
CellCept (RO) *316*, *317*, *863*, *864*, *1099*, *1100*
CellCept(RO) *317*, *863*, *1100*
Cellufresh(AG) *700*
Celluvisc(AG) *700*
Celsentri(VI) *1249*
Cephalex 250(CR) *208*
Cephalex 500(CR) *207*, *208*
Cephalexin AN (EA) *207*, *208*
Cephalexin generichealth(GQ) *207*, *208*
CEPHALOTHIN 209
Cephazolin Alphapharm(AF) *209*
Ceptolate(AF) *316*, *317*, *863*, *864*, *1099*, *1100*
CERITINIB 248
Certican(NV) *315*, *863*, *1099*
CERTOLIZUMAB PEGOL 391, 393, 395, 399, 400, 402, 405, 407
Cerumol(UN) *1579*
CETIRIZINE 1578
CETRORELIX 1540
Cetrotide(SG) *1540*
C-Flox 250 (AL) *220*
C-Flox 500 (AL) *219*
C-Flox 750 (AL) *219*
Champix(PF) *659*
Chem mart Alendronate Plus D3 70 mg/140 mcg (CH) . *571*
Chem mart Alendronate Plus D3 70 mg/140 mcg(CH) *1572*
Chem mart Alendronate Plus D3 70 mg/70 mcg (CH) ... *572*
Chem mart Alendronate Plus D3 70 mg/70 mcg(CH) .. *1572*
Chem mart Allopurinol(CH) *566*
Chem mart Amitriptyline(CH) *635*
Chem mart Amlodipine(CH) *113*
Chem mart Amoxycillin and Clavulanic Acid(CH) .. *206*, *207*
Chem mart Atenolol (CH) *110*
Chem mart Atorvastatin (CH) *131*, *132*
Chem mart Azithromycin (CH)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*
Chem mart Azithromycin(CH)
.Repatriation Pharmaceutical Benefits Scheme *1570*
Chem mart Bisoprolol (CH) *110*
Chem mart Candesartan (CH) *122*
Chem mart Candesartan HCTZ 16/12.5 (CH) *125*
Chem mart Candesartan HCTZ 32/12.5 (CH) *125*
Chem mart Candesartan HCTZ 32/25 (CH) *125*
Chem mart Candesartan(CH) *122*
Chem mart Carvedilol 12.5 mg (CH) *112*
Chem mart Carvedilol 25 mg (CH) *112*
Chem mart Carvedilol 3.125 mg(CH) *112*
Chem mart Carvedilol 6.25 mg (CH) *112*
Chem mart Celecoxib (CH) *564*
Chem mart Citalopram(CH) *637*
Chem mart Clarithromycin (CH) *214*
Chem mart Clindamycin(CH) *216*, *217*
Chem mart Clopidogrel(CH) *87*, *1559*
Chem mart Clopidogrel/Aspirin 75/100 (CH) *88*
Chem mart Donepezil(CH) *650*, *651*
Chem mart Doxycycline (CH) *198*, *199*, *200*
Chem mart Doxycycline(CH) *199*
Chem mart Duloxetine(CH) *642*
Chem mart Escitalopram(CH) *637*, *638*
Chem mart Fluoxetine (CH) *639*
Chem mart Frusemide (CH) *107*
Chem mart Gliclazide MR (CH) *56*
Chem mart Gliclazide(CH) *57*
Chem mart Indapamide SR (CH) *107*
Chem mart Irbesartan (CH) *123*
Chem mart Irbesartan HCTZ (CH) *126*
Chem mart Isosorbide Mononitrate(CH) *104*
Chem mart Latanoprost (CH) *687*
Chem mart Lercanidipine(CH) *113*
Chem mart Letrozole (CH) *303*
Chem mart Lisinopril(CH) *116*
Chem mart Meloxicam (CH) *560*
Chem mart Meloxicam 15 mg (CH) *560*
Chem mart Meloxicam 7.5 mg (CH) *560*
Chem mart Metformin (CH) *56*
Chem mart Metformin 1000 (CH) *56*
Chem mart Metformin XR 1000(CH) *56*
Chem mart Metformin XR 500(CH) *56*
Chem mart Metoprolol (CH) *111*
Chem mart Mirtazapine (CH) *643*
Chem mart Montelukast(CH) *676*
Chem mart Olanzapine (CH) *619*, *620*
Chem mart Omeprazole (CH) *33*
Chem mart Paroxetine (CH) *640*
Chem mart Perindopril(CH) *116*, *117*
Chem mart Perindopril/ Indapamide 4/1.25(CH) *120*
Chem mart Pioglitazone(CH) *69*
Chem mart Pravastatin(CH) *133*, *134*
Chem mart Prazosin (CH) *106*
Chem mart Quetiapine (CH) *623*, *624*
Chem mart Rabeprazole (CH) *35*
Chem mart Ramipril (CH) *117*, *118*
Chem mart Ranitidine(CH) *30*
Chem mart Rizatriptan (CH) *596*
Chem mart Rosuvastatin (CH) *134*, *135*, *136*, *137*
Chem mart Roxithromycin(CH) *216*
Chem mart Sertraline(CH) *640*
Chem mart Sildenafil (CH) *1568*
Chem mart Simvastatin(CH) *137*, *138*, *139*
Chem mart Sumatriptan (CH) *596*, *597*
Chem mart Tramadol (CH) *591*, *592*
Chem mart Tramadol SR (CH) *591*
Chem mart Valaciclovir (CH) *233*, *234*
Chem mart Venlafaxine XR(CH) *644*
Chem mart Zopiclone (CH) *1575*
Chemists' Own Laxative with Senna(RW) *1555*
Chemists' Own Macrogol with Electrolytes (RW) *46*, *750*
CHLORAMBUCIL 238
CHLORAMPHENICOL 677
CHLORHEXIDINE 1554
CHLORPROMAZINE 18, 615
Chlorsig(QA) *677*

CHLORTALIDONE 107
Chlorvescent(AS) *80*
Cholstat 10(AF) *133*
Cholstat 20 (AF) *133*
Cholstat 40 (AF) *133*, *134*
Cholvastin(RA) *133*, *134*
CHORIOGONADOTROPIN ALFA 1537
Cialis(LY) *1568*
CICLESONIDE 672
CICLOSPORIN 555, 955, 1191
Cifran(RA) *219*
Cilamox (QA) *201*, *202*
Cilamox(QA) *201*
Cilicaine V(FM) *203*
Cilicaine VK(FM) *203*, *204*
Cilicaine(QA) *18*, *204*
Cilopam-S (ER) *637*, *638*
CiloQuin(NM) *679*
Ciloxan(NV)
.SENSORY ORGANS *679*, *707*
CIMETIDINE 29
Cimzia(UC) *391*, *392*, *395*, *399*, *400*, *402*, *405*, *407*, *410*
CIPLA IMATINIB ADULT(LR) *261*, *262*, *263*, *265*, *268*, *269*, *270*
Cipramil(LU) *637*
CIPROFLOXACIN
.ANTIINFECTIVES FOR SYSTEMIC USE 218, 219
.SENSORY ORGANS 678, 679, 706
Ciprofloxacin AN (EA) *219*
Ciprofloxacin Sandoz (SZ) *219*
Ciprofloxacin Sandoz(SZ) *219*, *220*
Ciprofloxacin-BW(GQ) *219*
Ciprol 250 (RW) *220*
Ciprol 500(RW) *219*
Ciprol 750 (RW) *219*
Ciproxin 250(BN) *220*
Ciproxin 500(BN) *219*
CITALOPRAM 637
Citalopram Actavis (EA) *637*
Citalopram Actavis (ED) *637*
Citalopram AN(EA) *637*
Citalopram AN(EF) *637*
Citalopram Sandoz (SZ) *637*
CITRULLINE 741
Citrulline 1000(VF) *741*
Citrulline Easy(OH) *741*
CITRULLINE WITH CARBOHYDRATE 741
Clarac(ED) *214*
Claratyne(BN) *1578*
Clarihexal (HX) *214*
Clarithro 250(RW) *214*
CLARITHROMYCIN 214, 830, 1065
Clarithromycin AN (EA) *214*
Clarithromycin Sandoz(SZ) *214*
Clavam 875 mg/125 mg (CR) *206*, *207*
Cleocin (FZ) *216*, *217*
Clexane(SW) *84*
Climara 100(BN) *182*
Climara 25(BN) *182*
Climara 50(BN) *182*
Climara 75(BN) *182*
CLINDAMYCIN 216, 217
Clindamycin BNM(BZ) *216*, *217*
Clindamycin-Link (LI) *216*, *217*
Clindamyk(AF) *216*, *217*
Clobemix (ED) *641*
CLOBETASOL 174
Clobex(GA) *174*
CLODRONATE 567
Clofen 10 (AF) *565*
Clofen 25 (AF) *565*
Clomid(SW) *186*
CLOMIFENE 186
CLOMIPRAMINE 635
Clonac 25 (RW) *558*, *559*, *751*
Clonac 50 (RW) *558*, *559*, *751*
CLONAZEPAM 18, 598, 599, 759
Clonea 3 Day Cream (AF) *1566*
Clonea 6 Day Cream(AF) *1567*
Clonea(AF) *1560*
CLONIDINE 105
CLOPIDOGREL 86, 87, 1559
CLOPIDOGREL + ASPIRIN 88
Clopidogrel AN (EA) *87*, *1559*
Clopidogrel GH (GQ) *88*
Clopidogrel GH(GQ) *1559*
Clopidogrel RBX(RA) *87*
Clopidogrel Sandoz (SZ) *87*
Clopidogrel Winthrop plus aspirin(WA) *88*
Clopidogrel Winthrop(WA) *87*
Clopidogrel/Aspirin Actavis 75/100(EA) *88*
Clopidogrel/Aspirin Sandoz 75/100 (SZ) *88*
Clopidogrel-DRLA(RZ) *87*
Clopidogrel-GA(EA) *86*, *88*
Clopine 100(PF) *970*, *1207*, *1252*
Clopine 200(PF) *970*, *1207*, *1252*
Clopine 25(PF) *970*, *1207*, *1252*
Clopine 50(PF) *970*, *1207*, *1252*
Clopine Suspension(PF) *970*, *1207*, *1252*
Clopixol Depot(LU) *618*
CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX 1257, 1258, 1259
CLOTRIMAZOLE
.Repatriation Pharmaceutical Benefits Scheme 1560, 1566
Clovix 75 (RW) *86*
Clovix 75(RW) *88*
CLOZAPINE 970, 1206, 1251
Clozaril 100 (GO) *970*, *1207*, *1252*
Clozaril 25 (GO) *970*, *1207*, *1252*
COAL TAR SOLUTION + PHENOL + PRECIPITATED SULFUR 1563
COAL TAR SOLUTION + TAR + SALICYLIC ACID 1565
Cobal-B12(JU) *99*
Coban 1584(MM) *1581*
Coban 2(MM) *1581*
COBIMETINIB 248
Codalgin Forte (FM) *589*
Codapane Forte 500/30(AL) *589*
CODEINE
.NERVOUS SYSTEM 576
.RESPIRATORY SYSTEM 677
Co-Diovan 160/12.5 (NV) *127*
Co-Diovan 160/25 (NV) *127*
Co-Diovan 320/12.5 (NV) *128*
Co-Diovan 320/25 (NV) *128*
Co-Diovan 80/12.5 (NV) *127*
Colaxsen (QA) *1555*
Colazide(PK) *49*
COLCHICINE 567
Colese(AF) *1554*
COLESTYRAMINE 140
Colgout(AS) *567*
Colifoam(HM) *49*
Colofac(GO) *1554*
Coloxyl 50(FM) *1555*
Coloxyl with Senna(FM) *1555*
CombiDERM 651027(CC) *1590*
CombiDERM 651031(CC) *1590*
Combigan(AG) *682*, *683*

Combivir(VI) *1246*
Comfarol Forte (SZ) *589*
Comfeel Plus Pressure Relieving 3350(CT) *1593*
Comfeel Plus Pressure Relieving 3353(CT) *1593*
Comfeel Plus Transparent 3530(CT) *1592*
Comfeel Plus Transparent 3533(CT) *1592*
Comfeel Plus Transparent 3536(CT) *1592*
Comfeel Plus Ulcer Dressing 3110(CT) *1593*
Comfeel Purilon Gel 3900(CT) *1594*
Comfeel SeaSorb Dressing 3705(CT) *1586*
Comfeel SeaSorb Dressing 3710(CT) *1585*
Comfeel SeaSorb Filler 3740(CT) *1585*
Comprilan 01027-00(BV) *1580*
Comtan(NV) *615*
Concerta(JC) *647*, *648*
Copaxone(TB) *307*, *308*
CoPlavix (SW) *88*
Coralan(SE) *105*
Corbeton 40(AF) *109*
Cordarone X 100 (SW) *102*
Cordarone X 200 (SW) *102*
Cordilox 180 SR(GT) *114*
Cordilox SR(GT) *114*
CORIFOLLITROPIN ALFA 1538
Cortate(AS) *192*
Cortic-DS 1%(FM) *164*, *165*
Cortic-DS 1%(QA) *1564*
CORTISONE 192
Cortival 1/2(FM) *167*, *168*
Cortival 1/5(FM) *167*
Cosamide 50 (AF) *300*
Cosdor (QA) *685*
Co-Senna(PP) *1555*
Cosentyx(NV) *505*, *506*, *508*, *510*, *513*, *516*, *520*, *523*, *527*
Cosopt(MF) *685*
Cosudex(AP) *300*
Cotellic(RO) *248*, *249*
Coumadin(QA) *82*
Coveram 10/10(SE) *121*
Coveram 10/5(SE) *121*
Coveram 5/10(SE) *121*
Coveram 5/5(SE) *121*
Coversyl 10mg(SE) *117*
Coversyl 2.5mg(SE) *116*
Coversyl 5mg(SE) *117*
Coversyl Plus 5mg/1.25mg(SE) *120*
Coversyl Plus LD 2.5mg/0.625mg(SE) *119*
Cozavan(AF) *123*
Creon 10,000(GO) *53*
Creon 25,000(GO) *53*
Creon 40,000(GO) *53*
Creon Micro(GO) *53*
Crestor(AP) *134*, *135*, *136*, *137*
Crinone 8%(SG) *1537*
Crixivan 400 mg(MK) *1235*
CRIZOTINIB 249
CROMOGLYCATE
.Repatriation Pharmaceutical Benefits Scheme 1577
.RESPIRATORY SYSTEM 674
Crosuva 10 (ZP) *134*, *135*, *136*, *137*
Crosuva 20 (ZP) *134*, *135*, *136*, *137*
Crosuva 40 (ZP) *134*, *135*, *136*, *137*
Crosuva 5 (ZP) *134*, *135*, *136*, *137*
Crysanal(IY) *563*, *753*
Curam (SZ) *207*
Curam Duo (SZ) *206*, *207*
Curam Duo 500/125 (SZ) *206*, *207*
Curam Duo Forte 875/125(SZ) *206*, *207*
Curity 4112(KE) *1589*
Cutifilm Plus 36361370(SN) *1586*
Cutifilm Plus 36361371(SN) *1587*
Cutilin Non-Stick Wound Pad 36361374(SN) *1596*
Cutilin Non-Stick Wound Pad 36361375(SN) *1596*
Cutinova Hydro 66047441(SN) *1591*
Cutinova Hydro 66047443(SN) *1591*
Cycloblastin(ZX) *239*
CYCLOPHOSPHAMIDE 239
Cyclosporin Sandoz(SZ) *555*, *956*, *1192*
Cyklokapron (PF) *98*
Cymbalta(LY) *642*
Cymevene(RO) *830*, *1066*, *1233*
Cyprocur 100 (QA) *186*, *300*
Cyprocur 50 (QA) *186*, *187*, *300*
Cyprone 100(AF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*
Cyprone(AF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
Cyprostat (SY)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
Cyprostat-100 (SY)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*
CYPROTERONE
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 300
.GENITO URINARY SYSTEM AND SEX HORMONES 186, 187
Cyproterone AN(EA)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
Cyproterone Sandoz (HX)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
Cyrotone(ER)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *187*
Cystadane(EU) *81*
Cystine 500(VF) *741*
CYSTINE WITH CARBOHYDRATE 741
DABIGATRAN 90, 91
DABRAFENIB 249, 250
DACLATASVIR 234, 832, 1067
DACLIZUMAB 492
Daivobet (LO) *163*
Daivobet 50/500 gel(LO) *163*
Daklinza(BQ) *234*, *235*, *832*, *1067*, *1068*
Daktarin Tincture(JT) *161*
Daktarin(JT) *161*, *162*
Dalacin C(PF) *216*, *217*
DALTEPARIN SODIUM 82, 83
DANAZOL 187
Dantrium(PF) *565*, *566*
DANTROLENE 565

Daonil(SW) *56*
DAPAGLIFLOZIN 76
DAPAGLIFLOZIN + METFORMIN 58
Dapa-Tabs(AF) *107*
DAPSONE
.ANTIINFECTIVES FOR SYSTEMIC USE 228
.DERMATOLOGICALS 175
Daraprim(RW) *662*
DARBEPOETIN ALFA 769, 1004
DARUNAVIR 1234
DARUNAVIR + COBICISTAT 1244
DASATINIB 250, 252, 254
DBL Cefepime (PF) *212*, *213*
DBL Zoledronic Acid (PF) *969*, *1205*
DBL Zoledronic Acid(PF) *969*, *1205*
Deca-Durabolin(AS) *81*
Decapeptyl(FP) *1541*
DEFERASIROX 993, 1230
DEFERIPRONE 993, 1230
DEGARELIX 303, 304
Delucon 100(DO) *623*
Delucon 200(DO) *623*
Delucon 25(DO) *624*
Delucon 300(DO) *623*
DENOSUMAB 574, 575
Denpax(AF) *585*, *586*, *587*, *588*
Densate 70(DO) *567*
Depo-Medrol(PF) *194*
Depo-Nisolone(FZ) *194*
Depo-Provera(PF) *179*
Depo-Ralovera(FZ) *179*
Depreta 30 (DO) *642*
Depreta 60 (DO) *642*
Deptran 10(AF) *636*
Deptran 25(AF) *636*
Deptran 50(AF) *636*
Deralin 10(AF) *109*
Deralin 160(AF) *109*
Deralin 40(AF) *109*
Dermatane (ER) *174*, *175*
Dermatane(ER) *175*
Descovy(GI) *1245*
Desfax(AF) *641*, *642*
DESFERRIOXAMINE 994, 1230
DESMOPRESSIN 190, 191
DESVEN (RW) *641*, *642*
DESVENLAFAXINE 641
Desvenlafaxine Actavis(EA) *642*
Desvenlafaxine GH XR (GQ) *641*, *642*
Desvenlafaxine Sandoz (SZ) *642*
DEXAMETHASONE
.SENSORY ORGANS 679
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 192
Dexamethasone Mylan(AF) *19*, *193*
DEXAMETHASONE SODIUM PHOSPHATE 19, 193
DEXAMFETAMINE 647
Dexmethsone(AS) *193*
DEXTRAN-70 + HYPROMELLOSE 701
Diabex 1000(AL) *56*
Diabex 850(AL) *56*
Diabex XR 1000(AL) *56*
Diabex XR(AL) *56*
Diabex(AL) *56*
Diaformin 1000(AF) *56*
Diaformin 850(AF) *56*
Diaformin XR (AF) *56*
Diaformin XR 1000 (AF) *56*
Diaformin(AF) *56*
Dialamine(SB) *742*
Diamicron 60mg MR(SE) *57*
Diamox(RW) *683*
Diapride 1(RW) *57*
Diapride 2(RW) *57*
Diapride 3(RW) *57*
Diapride 4(RW) *57*
Diasp SR (RW) *89*
Diastix(BN) *711*
DIAZEPAM 19, 632, 759
Diazepam Elixir(ON) *632*
Dibenyline(GH)
.CARDIOVASCULAR SYSTEM *109*
.GENITO URINARY SYSTEM AND SEX HORMONES *188*
Dibenzyline(BZ)
.CARDIOVASCULAR SYSTEM *109*
.GENITO URINARY SYSTEM AND SEX HORMONES *189*
Dicarz(AF) *112*
DICHLOROBENZENE WITH CHLORBUTOL AND ARACHIS OIL 1579
DICLOFENAC
.MUSCULO-SKELETAL SYSTEM 558
.Palliative Care 751
.Repatriation Pharmaceutical Benefits Scheme 1565
Diclofenac Amneal(ED) *558*, *559*, *751*
Diclofenac AN (EA) *558*, *559*, *751*
Diclofenac Sandoz(SZ) *558*, *559*, *751*
DICLOXACILLIN 204
DIDANOSINE 1237
Difflam(IA) *29*, *749*
Diflucan (PF) *223*
Diflucan(PF) *223*, *224*
DIGOXIN 100
Dilantin Infatabs(PF) *598*
Dilantin Sodium(PF) *598*
Dilantin(PF) *598*
Dilart (AF) *124*
Dilart HCT 160/12.5(AF) *127*
Dilart HCT 160/25(AF) *127*
Dilart HCT 320/12.5(AF) *128*
Dilart HCT 320/25(AF) *128*
Dilart HCT 80/12.5(AF) *127*
Dilatrend 12.5 (PB) *112*
Dilatrend 25 (PB) *112*
Dilatrend 6.25 (PB) *112*
Dilaudid(MF) *577*, *578*
Dilaudid-HP(MF) *577*
DILTIAZEM 114
Diltiazem Actavis(ED) *114*
Diltiazem AN (EA) *114*
Diltiazem Sandoz CD(SZ) *114*, *115*
Diltiazem Sandoz(SZ) *114*
DIMETHYL FUMARATE 660
DIMETICONE-350 + GLYCEROL 1562
Dimirel (AV) *57*
Diovan(NV) *124*
Dipentum(IX) *52*
DIPHENOXYLATE + ATROPINE SULFATE MONOHYDRATE 48
Diphereline(IS) *298*, *299*
DIPHTHERIA TOXOID + TETANUS TOXOID 19, 238
Diprosone(MK) *165*, *166*, *167*
DIPYRIDAMOLE 88
DIPYRIDAMOLE + ASPIRIN 88
DISOPYRAMIDE 101
Distaph 250(AF) *204*
Distaph 500(AF) *204*, *205*
Dithiazide(PL) *106*
Ditropan(SW) *188*

Dizole 100 (AF) *223*
Dizole 200(AF) *223*
Dizole 50(AF) *223*
docomega(VF) *741*
DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE 741
DOCUSATE
.Repatriation Pharmaceutical Benefits Scheme 1555, 1579
DOCUSATE + SENNOSIDE B 1555
DOCUSATE + SENNOSIDES 1555
Dolapril 0.5(RW) *119*
Dolapril 1(RW) *119*
Dolapril 2(RW) *119*
Dolapril 4(RW) *119*
DOLUTEGRAVIR 1248
DOLUTEGRAVIR + ABACAVIR + LAMIVUDINE 1244
DOMPERIDONE 36
DONEPEZIL 649, 650
Donepezil AN (EA) *650*, *651*
Donepezil generichealth (GQ) *650*, *651*
Donepezil RBX(RA) *650*, *651*
Donepezil Sandoz (SZ) *650*, *651*
Donepezil Sandoz(SZ) *650*, *651*
Donepezil-DRLA(RZ) *650*, *651*
DORNASE ALFA 987, 1224
Doryx(YN) *198*, *199*, *200*
DORZOLAMIDE 684
DORZOLAMIDE + TIMOLOL 684, 685
DORZOLAMIDE/TIMOLOL AN 20/5(EA) *685*
Dorzolamide/Timolol Sandoz 20/5 (SZ) *685*
Dostinex (PF) *177*, *178*
Dothep 25(AF) *636*
Dothep 75(AF) *636*
DOTHIEPIN 636
DOXEPIN 636
DOXORUBICIN HYDROCHLORIDE-PEGYLATED LIPOSOMAL 837, 1073
Doxsig(RW) *198*, *199*, *200*
DOXYCYCLINE 198, 199, 200
Doxycycline AN (EA) *198*, *199*, *200*
Doxycycline AN(EA) *199*, *200*
Doxycycline Sandoz (HX) *199*
Doxycycline Sandoz(HX) *198*, *199*, *200*
Doxylin 100 (AF) *199*
Doxylin 100(AF) *198*, *199*, *200*
Doxylin 50 (AF) *200*
D-Penamine(AL) *565*
DRESSING ACTIVATED CHARCOAL MALODOROUS WOUND 1584
DRESSING ALGINATE CAVITY WOUND 1584, 1585
DRESSING ALGINATE SUPERFICIAL WOUND 1585
DRESSING ALGINATE WITH MANUKA HONEY 1586
DRESSING FILM 1586
DRESSING FILM ISLAND 1586
DRESSING FOAM HEAVY EXUDATE 1587
DRESSING FOAM MODERATE EXUDATE 1587
DRESSING FOAM WITH SILICONE 1587
DRESSING FOAM WITH SILICONE AND SILVER 1587
DRESSING FOAM WITH SILICONE HEAVY EXUDATE 1588
DRESSING FOAM WITH SILICONE LIGHT EXUDATE 1588
DRESSING FOAM WITH SILICONE MODERATE EXUDATE 1588
DRESSING FOAM WITH SILVER 1589
DRESSING GAUZE ABSORBENT 1589
DRESSING GAUZE EYE 1589
DRESSING GAUZE PARAFFIN 1589
DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE ACETATE 1590
DRESSING HYDROACTIVE DEBRIDEMENT 1590
DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM 1590
DRESSING HYDROACTIVE SUPERFICIAL WOUND LIGHT EXUDATE 1591
DRESSING HYDROACTIVE SUPERFICIAL WOUND MODERATE EXUDATE 1591
DRESSING HYDROCOLLOID CAVITY WOUND 1591
DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE 1591, 1592
DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE 1592, 1593
DRESSING HYDROFIBRE ALTERNATE TO ALGINATES 1593
DRESSING HYDROFIBRE GELLING FIBRE 1593
DRESSING HYDROFIBRE WITH SILVER 1594
DRESSING HYDROGEL 1594
DRESSING HYDROGEL AMORPHOUS 1594
DRESSING HYDROGEL FOAM 1595
DRESSING HYDROGEL RIBBON 1595
DRESSING HYDROGEL SHEET 1595
DRESSING NON ADHERENT 1595, 1596
DRESSING TULLE NON GAUZE PARAFFIN 1596
DRESSING WITH SILVER 1596
Drixine(BN) *1577*
Dronalen Plus D-Cal(AF) *572*
Dronalen Plus(AL) *571*
DRY PSYLLIUM HUSK 1555
Dulcolax(VZ) *44*, *750*, *1555*
DULOXETINE 642
Duloxetine AN(EA) *642*
Duocal(SB) *745*
DuoCover(AV) *88*
Duodart 500ug/400ug(GK) *189*, *1569*
DuoDERM CGF 187660(CC) *1592*
DuoDERM CGF 187662(CC) *1592*
DuoDERM Extra Thin 187955(CC) *1591*
DuoDERM Gel 187990(CC) *1594*
DuoDERM Gel H7987(CC) *1594*
DuoDERM Paste 187930(CC) *1591*
Duodopa(VE) *611*, *969*, *1206*
Duofilm Solution(GK) *1565*
DuoPlidogrel (GZ) *88*
Duotrav(NV) *688*
Durafiber 66800560(SN) *1593*
Durafiber 66800561(SN) *1593*
Durafiber 66800563(SN) *1593*
Duride (AF) *104*
Durogesic 100 (JC) *588*
Durogesic 12 (JC) *586*
Durogesic 25 (JC) *586*
Durogesic 50 (JC) *587*
Durogesic 75 (JC) *587*
Duro-K(NM) *80*
Duro-Tuss(IA) *1578*
DUTASTERIDE 189, 1569
DUTASTERIDE + TAMSULOSIN 189, 1569
Dutran 100(EA) *588*
Dutran 12(EA) *586*
Dutran 25(EA) *586*
Dutran 50(EA) *587*
Dutran 75(EA) *587*
Dysport(IS) *1258*, *1259*
DYTREX 30 (RW) *642*
DYTREX 60 (RW) *642*
E.E.S. 200(GH) *215*
E.E.S. Granules(GH) *215*
EAA Supplement(VF) *742*
Ear Clear for Ear Wax Removal(KY) *1579*

Easiphen(SB) *737*
Ebixa (LU) *655*, *656*
ECULIZUMAB 855, 856, 857, 858, 1091, 1092, 1093, 1095
Edecrin(FK) *108*
Edronax(PF) *644*
Edurant(JC) *1243*
EFAVIRENZ 1241
Efexor-XR (PF) *644*
Efexor-XR(PF) *644*
Effient(LY) *89*
Efudix (IA) *1570*
Egoderm Cream(EO) *1565*
Egoderm Ointment(EO) *1565*
Egopsoryl-TA(EO) *1563*
Elastoplast 2225(BE) *1582*
Elastoplast 2226(BE) *1582*
Elastoplast 2227(BE) *1582*
Elaxine SR 150(ZP) *644*
Elaxine SR 37.5 (ZP) *644*
Elaxine SR 75(ZP) *644*
ELBASVIR + GRAZOPREVIR 235, 832, 833, 1068
Eldepryl(AS) *615*
Eleanor 150/30 ED(EA) *178*
EleCare LCP(AB) *717*, *718*
EleCare(AB) *714*, *715*, *716*
ELETRIPTAN 595
Eleuphrat(FR) *165*, *166*, *167*
Eleva 100 (AF) *640*
Eleva 50 (AF) *640*
Elidel(HM) *175*
Eligard 1 month(TL) *297*
Eligard 3 month(TL) *297*
Eligard 4 month(TL) *297*
Eligard 6 month(TL) *297*
Eliquis(BQ) *92*, *93*, *94*
Elocon Alcohol Free(MK) *171*, *172*, *173*
Elocon(MK) *171*, *172*, *173*, *1564*
Elonva(MK) *1538*
ELTROMBOPAG 763, 998
Emend IV(MK) *42*
Emend(MK) *41*
EMEXLON (RW) *36*
EMPAGLIFLOZIN 77
EMPAGLIFLOZIN + METFORMIN 59, 60
EMTRICITABINE 1237
EMTRICITABINE + RILPIVIRINE + TENOFOVIR ALAFENAMIDE 1245
EMTRICITABINE + TENOFOVIR ALAFENAMIDE 1245
Emtriva(GI) *1237*
E-Mycin 200(AF) *215*
E-Mycin 400(AF) *215*
E-Mycin(AF) *215*
ENALAPRIL 115
ENALAPRIL + HYDROCHLOROTHIAZIDE 119
Enalapril Actavis(ED) *115*
Enalapril generichealth (GQ) *115*
Enalapril Sandoz(SZ) *115*
Enalapril/HCT Sandoz(SZ) *119*
Enbrel (PF) *434*, *435*, *437*, *439*, *446*, *450*, *454*, *457*, *474*
Enbrel(PF) *420*, *422*, *424*, *425*, *427*, *432*, *435*, *437*, *439*, *442*, *447*, *450*, *454*, *457*, *468*, *474*, *888*, *1125*
Endep 10(AF) *635*
Endep 25(AF) *635*
Endep 50(AF) *635*
Endometrin(FP) *1537*
Endone(QA) *582*, *583*
Endoxan(BX) *239*
Energivit(SB) *741*
ENFUVIRTIDE 1248
Enidin(PE) *682*
Enlafax-XR (AF) *644*
ENOXAPARIN SODIUM 84
Enstilar(LO) *164*
ENTAC (LR) *1238*
ENTACAPONE 615
ENTECAVIR 1237, 1238
Entecavir Amneal(EA) *1238*
Entecavir APOTEX (TX) *1238*
Entecavir GH(GQ) *1238*
Entecavir Mylan (AF) *1238*
ENTECAVIR RBX(RA) *1238*
Entecavir Sandoz (SZ) *1238*
ENTECLUDE(RW) *1238*
Entresto(NV) *130*
ENTRIP (RW) *635*
Entyvio(TK) *870*, *875*, *1106*, *1112*
ENZALUTAMIDE 300
Epclusa(GI) *238*, *835*, *1071*
Epiduo(GA) *174*
Epilim EC(SW) *601*
Epilim Liquid(SW) *601*
Epilim Syrup(SW) *601*
Epilim(SW) *601*
EpiPen Jr.(AL)
.CARDIOVASCULAR SYSTEM *103*
.RESPIRATORY SYSTEM *675*
EpiPen(AL)
.CARDIOVASCULAR SYSTEM *103*
.RESPIRATORY SYSTEM *675*
Epiramax 100 (RW) *607*
Epiramax 200 (RW) *607*
Epiramax 25 (RW) *608*
Epiramax 50 (RW) *608*
EPLERENONE 108
Eplerenone AN(EA) *108*
EPOETIN ALFA 770, 1005
EPOETIN BETA 770, 1005
EPOETIN LAMBDA 771, 1006
EPOPROSTENOL 788, 1023
Eprex 1000(JC) *770*, *1005*
Eprex 10000(JC) *770*, *1005*
Eprex 20,000(JC) *770*, *1005*
Eprex 2000(JC) *770*, *1005*
Eprex 3000(JC) *770*, *1005*
Eprex 40,000(JC) *770*, *1005*
Eprex 4000(JC) *770*, *1005*
Eprex 5000(JC) *770*, *1005*
Eprex 6000(JC) *770*, *1005*
Eprex 8000(JC) *770*, *1005*
EPROSARTAN 122
EPROSARTAN + HYDROCHLOROTHIAZIDE 125
EPTIFIBATIDE 89
Erivedge(RO) *295*
ERLOTINIB 255, 256
Eryc(YN) *215*
ERYTHROMYCIN 215
ERYTHROMYCIN ETHYLSUCCINATE 215
Esbriet(RO) *558*
Escicor 10(RA) *637*
Escicor 20(RA) *638*
ESCITALOPRAM 637, 638
Escitalopram AN (EA) *637*, *638*
Escitalopram generichealth (GQ) *637*, *638*
Escitalopram Sandoz(HX) *637*, *638*
Escitalopram-DRLA(RZ) *637*, *638*
Esipram (CF) *637*, *638*
Esipram(CF) *638*
Esitalo(SZ) *637*, *638*
Eskazole(AS) *663*
ESOMEPRAZOLE 30, 31

ESOMEPRAZOLE (&) CLARITHROMYCIN (&) AMOXICILLIN 35
Esomeprazole ACTAVIS(EA) *31*, *32*
Esomeprazole Apotex(TX) *30*, *31*, *32*
Esomeprazole GH (GQ) *30*, *31*, *32*
Esomeprazole GxP(AF) *30*, *31*, *32*
Esomeprazole RBX (RA) *30*, *31*, *32*
ESOMEPRAZOLE SANDOZ Hp7(SZ) *35*
Esomeprazole Sandoz(SZ) *30*, *31*, *32*
Esomeprazole SZ (HX) *30*, *31*, *32*
ESPLER (RW) *108*
Essential Amino Acid Mix(SB) *742*
ESSENTIAL AMINO ACIDS FORMULA 741
ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C 742
ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS 742
Estalis continuous 50/140(SZ) *184*
Estalis continuous 50/250(SZ) *184*
Estalis sequi 50/140(SZ) *184*
Estalis sequi 50/250(SZ) *184*
Estamane (JU) *302*, *303*
Estraderm MX 100(JU) *183*
Estraderm MX 25(JU) *182*
Estraderm MX 50(JU) *182*
ESTRADIOL 181, 182
ESTRADIOL (&) ESTRADIOL + DYDROGESTERONE 184
ESTRADIOL + DYDROGESTERONE 183
ESTRADIOL + NORETHISTERONE ACETATE 184
Estradot 100(SZ) *183*
Estradot 25(SZ) *182*
Estradot 37.5(SZ) *182*
Estradot 50(SZ) *182*
Estradot 75(SZ) *182*
ESTRIOL 183
ETACRYNIC ACID 108
ETANERCEPT410, 412, 414, 415, 418, 420, 422, 425, 427, 432, 435, 437, 439, 442, 447, 450, 454, 457, 468, 882, 1118
ETHOSUXIMIDE 598
ETONOGESTREL 179
ETOPOSIDE 242
ETRAVIRINE 1242
EUCALYPTUS OIL + MENTHOL + METHYL SALICYLATE 1571
Eucerin(BE) *1562*
Eutroxsig(FM) *196*
Evelyn 150/30 ED (GQ) *178*
EVEROLIMUS
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 256, 257, 258, 315
.Highly Specialised Drugs Program (Private Hospital) 862
.Highly Specialised Drugs Program (Public Hospital) 1099
Evifyne (EL) *575*
Eviplera(GI) *1247*
Evista(LY) *575*
EVOLOCUMAB 140
Evotaz(BQ) *1234*
Exaccord(RA) *302*, *303*
Exelon Patch 10(NV) *653*, *654*
Exelon Patch 15(NV) *653*, *654*
Exelon Patch 5(NV) *653*, *654*
Exelon(NV) *653*, *654*
EXEMESTANE 302
Exemestane AN (EA) *302*, *303*
Exemestane GH(GQ) *302*, *303*
Exemestane Sandoz (SZ) *302*, *303*
EXENATIDE 74, 75
Exforge 10/160(NV) *128*
Exforge 10/320(NV) *128*
Exforge 5/160(NV) *128*
Exforge 5/320(NV) *128*
Exforge 5/80(NV) *128*
Exforge HCT 10/160/12.5(NV) *129*
Exforge HCT 10/160/25(NV) *130*
Exforge HCT 10/320/25(NV) *129*
Exforge HCT 5/160/12.5(NV) *129*
Exforge HCT 5/160/25(NV) *129*
Exjade(NV) *993*, *1230*
Extine 20(RW) *640*
Eylea(BN) *689*, *692*
EZETIMIBE 141
EZETIMIBE + ATORVASTATIN 144, 147
EZETIMIBE + SIMVASTATIN 149, 152
Ezetrol(MK) *144*
Ezovir (AF) *231*
Ezovir(AF) *230*, *231*, *232*
FAMCICLOVIR 230, 231
Famciclovir AN (EA) *230*, *231*, *232*
Famciclovir AN(EA) *231*
Famciclovir FBM(FO) *230*
Famciclovir generichealth 250 (GQ) *231*
Famciclovir generichealth 250(GQ) *230*
Famciclovir generichealth 500 (GQ) *232*
Famciclovir Sandoz (SZ) *230*, *231*
Famciclovir Sandoz(SZ) *231*, *232*
Famciclovir SCP 250 (CR) *231*
Famciclovir SCP 250(CR) *230*
Famciclovir-GA (ED) *230*, *231*
Famciclovir-GA(ED) *231*, *232*
Famlo (RA) *230*
Famlo(RA) *231*
FAMOTIDINE 29
Famotidine AN (EA) *29*
Famotidine Sandoz(SZ) *29*
Famvir (HX) *231*, *232*
Famvir(HX) *230*, *231*
Fareston(AS) *300*
Fasigyn(PF) *222*
Faverin 100 (RW) *640*
Faverin 50 (RW) *639*
Favic 125(RW) *231*
Favic 250 (RW) *230*
Favic 250(RW) *231*
Favic 500 (RW) *231*
Favic 500(RW) *232*
Fawns and McAllan Proprietary Limited(FM)
.NERVOUS SYSTEM *576*, *598*
.RESPIRATORY SYSTEM *677*
Febridol (EA) *593*, *1573*, *1574*
FEBUXOSTAT 566
Feldene(PF) *560*, *561*
Feldene-D(PF) *561*
Felodil XR 10(RW) *113*
Felodil XR 5(RW) *113*
FELODIPINE 113
Felodur ER 10 mg (TX) *113*
Felodur ER 2.5 mg(TX) *113*
Felodur ER 5 mg (TX) *113*
Femara 2.5 mg(NV) *303*
Femme-Tab ED 20/100(AE) *178*
Femme-Tab ED 30/150(AE) *178*
Femolet (AF) *303*
Femoston 1/10(GO) *184*
Femoston 2/10(GO) *184*
Femoston-Conti(GO) *184*
Fenac (AF) *558*, *559*, *751*
Fenac 25 (AF) *558*, *559*, *751*
Fendex ER (AF) *113*
Fendex ER(AF) *113*

FENOFIBRATE 139
Fenpatch 100 (ZP) *588*
Fenpatch 12 (ZP) *586*
Fenpatch 25 (ZP) *586*
Fenpatch 50 (ZP) *587*
Fenpatch 75 (ZP) *587*
FENTANYL 585, 586, 587, 753, 754, 755, 756
Fentanyl Sandoz(SZ) *586*, *587*, *588*
Fentora(TB) *755*, *756*, *757*
Fera(QA) *303*
ferinject(VL) *98*
FERRIC PYROPHOSPHATE + THIAMINE + PYRIDOXINE + CYANOCOBALAMIN + LYSINE 1557
Ferriprox(TX) *993*, *994*, *1230*
Ferro-f-tab(AE) *99*, *1559*
Ferro-Liquid(AE) *98*
Ferrosig(SI) *98*
Ferro-tab(AE) *98*, *1559*
FERROUS FUMARATE 98, 1559
FERROUS FUMARATE + FOLIC ACID 99, 1559
FERROUS SULFATE 98
Fexal(SZ) *1578*
FEXOFENADINE 1578
Fibre Health Natural Granular(PP) *1555*
Fibsol 10 (RW) *116*
Fibsol 20 (RW) *116*
Fibsol 5 (RW) *116*
FILGRASTIM 839, 1074
Finasta (SZ) *1569*
FINASTERIDE 1569
Finasteride Alphapharm(AF) *1569*
Finasteride AN (EA) *1569*
Finasteride GH 5(GQ) *1569*
Finasteride-GA 5 (GN) *1569*
FINGOLIMOD 315
Finide (AL) *1569*
Finnacar(RW) *1569*
Finpro(RZ) *1569*
Firazyr(ZI) *100*
Firmagon 120mg(FP) *304*
Firmagon 80mg(FP) *304*
Fixta 60 (DO) *575*
Flagyl S(SW) *221*, *222*
Flagyl(SW) *221*, *222*
Flamazine(SN) *164*
Flarex(NV) *681*
FLECAINIDE 101
Flecainide Sandoz(SZ) *101*
Flecatab (AF) *101*
Flexidress 650941(CC) *1583*
Flixotide Accuhaler(GK) *672*
Flixotide Junior Accuhaler(GK) *672*
Flixotide Junior(GK) *672*
Flixotide(GK) *672*
Flolan(GK) *792*, *1027*
Flomaxtra(LS) *1569*
Flopen (AS) *205*, *206*
Florinef(QA) *192*
Fluanxol Concentrated Depot(LU) *618*
Fluanxol Depot(LU) *617*
Flucil(AS) *205*
Flucil(LN) *205*, *206*
FLUCLOXACILLIN 205, 206
Flucon(NV) *681*
FLUCONAZOLE 222, 223, 224
Fluconazole Alphapharm(AF) *223*, *224*
Fluconazole Sandoz (SZ) *223*
Fluconazole Sandoz(SZ) *223*, *224*
Fludara(GZ) *241*
FLUDARABINE 241
FLUDROCORTISONE ACETATE 191
FLUNITRAZEPAM 1575
FLUOROMETHOLONE 681
FLUOROMETHOLONE ACETATE 681
FLUOROURACIL 1570
FLUOTEX(RF) *639*
FLUOXETINE 639
Fluoxetine AN (EA) *639*
Fluoxetine generichealth (GQ) *639*
Fluoxetine Sandoz(SZ) *639*
Fluoxetine-GA(ED) *639*
FLUPENTIXOL DECANOATE 617
FLUTAMIDE 301
Flutamide MYLAN(AF) *301*
Flutamin(AF) *301*
FLUTICASONE 672
FLUTICASONE + FORMOTEROL (EFORMOTEROL) 668
FLUTICASONE + SALMETEROL 668, 669
Fluticasone + Salmeterol Cipla 125/25(LR) *669*
Fluticasone + Salmeterol Cipla 250/25(LR) *669*
Fluticasone Cipla Inhaler (LR) *672*
FLUTICASONE FUROATE + VILANTEROL 669, 670
flutiform 125/5(MF) *668*
flutiform 250/10(MF) *668*
flutiform 50/5(MF) *668*
FLUVASTATIN 132
FLUVOXAMINE 639
Fluvoxamine AN(ED) *639*, *640*
Fluvoxamine GA (EA) *639*, *640*
Fluzole 200(RW) *223*
FML Liquifilm (AG) *681*
FOLIC ACID 99, 1560
FOLINIC ACID 709, 710
FOLLITROPIN ALFA 184, 1538
FOLLITROPIN ALFA + LUTROPIN ALFA 1538
FOLLITROPIN BETA 185, 1539
Foltabs 500(PP) *99*, *1560*
Fonat (AL) *567*
FonatPlus (AF) *571*, *1572*
FonatPlus(AF) *572*
FONDAPARINUX 97
Foradile(SZ) *665*
Formet 1000 (RW) *56*
FORMET 500 (RF) *56*
FORMET 850 (RF) *56*
Formet Aspen 500(RW) *56*
Formet Aspen 850(RW) *56*
FORMOTEROL (EFORMOTEROL) 665
Forteo(LY)
.MUSCULO-SKELETAL SYSTEM *576*
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS *198*
Forxiga(AP) *77*
Fosamax Plus 70 mg/140 mcg(MK) *571*, *1572*
Fosamax Plus D-Cal(MK) *572*, *1572*
Fosamax Plus(MK) *572*, *1572*
FOSAMPRENAVIR 1234
FOSAPREPITANT 41
Fosetic 20/12.5 (ZP) *119*
FOSINOPRIL 115
FOSINOPRIL + HYDROCHLOROTHIAZIDE 119
Fosinopril/HCT Actavis 20/12.5(EA) *119*
Fosipril 10 (RW) *116*
Fosipril 20 (RW) *116*
Fosrenol(ZI) *708*, *709*, *994*, *1231*
Fragmin(PF) *82*, *83*, *84*
Frakas (RW) *200*
FRAMYCETIN SULFATE 707
FRAMYCETIN SULFATE + GRAMICIDIN + DEXAMETHASONE 707

Fraxiparine Forte(AS) *85*
Fraxiparine(AS) *85*, *86*
FruitiVits(VF) *747*
Frusax(ER) *107*
Frusemide RBX (RA) *107*
Frusemide RBX(RA) *107*
Frusemide Sandoz (SZ) *19*, *107*
Frusemide Sandoz(SZ) *107*
Frusemide-Claris(AE) *19*, *107*
Fucidin(CS) *221*
Fungilin(QA) *29*
FUROSEMIDE (FRUSEMIDE) 19, 107
FUROSEMIDE AN (EA) *107*
FUSIDATE 221
Fuzeon(RO) *1248*
Fybogel(RC) *1555*
Fycompa(EI) *606*, *607*
GA express 15(VF) *734*
GA gel(VF) *734*
GA1 Anamix infant(SB) *734*
GA1 Anamix Junior(NU) *734*
Gabacor (CR) *602*
GABAPENTIN
.NERVOUS SYSTEM 602
.Repatriation Pharmaceutical Benefits Scheme 1574
Gabapentin 300(CR) *1574*
Gabapentin 400(CR) *1574*
Gabapentin AN (EA) *602*
Gabapentin AN(EA)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Gabapentin AN(EA)
.NERVOUS SYSTEM *602*
Gabapentin Aspen 100 (RW) *1574*
Gabapentin Aspen 100(RW)
.NERVOUS SYSTEM *602*
Gabapentin Aspen 300 (RW) *602*, *1574*
Gabapentin Aspen 400 (RW) *602*, *1574*
Gabapentin Aspen 600 (RW) *1574*
Gabapentin Aspen 600(RW)
.NERVOUS SYSTEM *602*
Gabapentin Aspen 800 (RW) *1574*
Gabapentin Aspen 800(RW)
.NERVOUS SYSTEM *602*
Gabapentin GH(GQ)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Gabapentin GH(GQ)
.NERVOUS SYSTEM *602*
Gabapentin Sandoz (SZ)
.NERVOUS SYSTEM *602*
Gabitril(OA) *601*
GALANTAMINE 651, 652
Galantamine AN SR (EA) *651*, *652*
Galantyl(AF) *651*, *652*
Galvumet 50/1000(NV) *67*
Galvumet 50/500(NV) *67*
Galvumet 50/850(NV) *67*
Galvus(NV) *74*
Gamine XR (RW) *651*, *652*
GANCICLOVIR 830, 1065, 1233
Ganfort 0.3/5(AG) *687*
GANfort PF 0.3/5(AG) *686*, *687*
GANIRELIX 1540
Gantin (EA)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Gantin(ED) *1574*
GAPENTIN (RF)
.NERVOUS SYSTEM *602*
GAPENTIN(RF) *602*
Gastrex(CR) *48*, *1556*
GAUZE AND COTTON TISSUE COMBINE ROLL 1597
GEFITINIB 258
Gelofusine(BR) *100*
GEMFIBROZIL 140
Generic Health Pty Ltd(GQ) *593*, *1573*, *1574*
Genoptic(AG) *677*, *678*
Genotropin GoQuick(PF) *1311*, *1512*, *1535*
Genotropin MiniQuick(PF) *1311*, *1512*, *1535*
Genotropin(PF) *1311*, *1512*, *1535*
Genox 10(AF) *299*
Genox 20(AF) *299*, *300*
GenRx Aciclovir (GX) *229*
GenRx Aciclovir(GX) *230*
GenRx Amiodarone(GX) *102*
GenRx Baclofen(GX) *565*
GenRx Clomipramine(GX) *636*
GenRx Cyproterone Acetate (GX)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *187*
GenRx Cyproterone Acetate(GX)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *300*
.GENITO URINARY SYSTEM AND SEX HORMONES *186*, *187*
GenRx Doxycycline (GX) *198*, *199*, *200*
GenRx Doxycycline(GX) *200*
GenRx Famotidine (GX) *29*
GenRx Fluoxetine (GX) *639*
GenRx Gabapentin (GX) *602*, *1574*
GenRx Gabapentin(GX)
.Repatriation Pharmaceutical Benefits Scheme *1574*
GenRx Gabapentin(GX)
.NERVOUS SYSTEM *602*
GenRx Gliclazide (GX) *57*
GenRx Indapamide (GX) *107*
GenRx Isosorbide Mononitrate(GX) *104*
GenRx Moclobemide(GX) *641*
GenRx Norfloxacin(GX) *220*
GenRx Paroxetine (GX) *640*
GenRx Perindopril/ Indapamide 4/1.25 (GX) *120*
GenRx Piroxicam(GX) *560*, *561*
GenRx Tamoxifen (GX) *299*
GenRx Terbinafine (GX) *162*, *163*
GenRx Terbinafine(GX) *1561*
GENTAMICIN
.ANTIINFECTIVES FOR SYSTEMIC USE 217
.SENSORY ORGANS 677
Genteal gel(NV) *702*, *703*
Genteal(NV) *702*
Genvoya(GI) *1248*
Gilenya(NV) *315*
GLATIRAMER ACETATE 307
Gliadel(EI) *239*
GLIBENCLAMIDE 56
GLICLAZIDE 56
GLIMEPIRIDE 57
Glimepiride AN(EA) *57*
Glimepiride Sandoz (SZ) *57*
GLIPIZIDE 57
Glivanib (JU) *261*, *262*, *263*, *265*, *268*, *269*, *270*
Glivec(AF) *260*, *261*, *262*, *263*, *264*, *265*, *268*, *269*, *270*
GlucaGen Hypokit(NO) *19*, *197*
GLUCAGON HYDROCHLORIDE 19, 197
Glucobay 100 (BN) *67*
Glucobay 50 (BN) *67*
Glucobete 1000(DO) *56*
Glucobete 500 (DO) *56*
Glucobete 850 (DO) *56*
GLUCOSE AND KETONE INDICATOR URINE 711

GLUCOSE INDICATOR URINE 711
Glucovance 250mg/1.25mg(AL) *63*
Glucovance 500mg/2.5mg(AL) *63*
Glucovance 500mg/5mg(AL) *63*
Glyade MR(AF) *56*
Glyade(AF) *57*
GLYCEROL 1556
GLYCERYL TRINITRATE..... 19, 103, 104
GLYCINE WITH CARBOHYDRATE 742
Glycine500(VF) *742*
GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS 742, 743
GLYCOMACROPEPTIDE FORMULA WITH LONG CHAIN POLYUNSATURATED FATTY ACID AND DOCOSAHEXAENOIC ACID AND LOW PHENYLALANINE 743
GLYCOPYRRONIUM 673
Glycosade(VF) *727*
Gold Cross(BI)
.Repatriation Pharmaceutical Benefits Scheme *1571*, *1577*, *1578*
GOLIMUMAB 474, 477, 481, 483, 485, 488
Gonal-f Pen(SG) *185*, *1538*
Gopten(GO) *119*
GOSERELIN 296
GOSERELIN (&) BICALUTAMIDE..... 297
GRANISETRON 36, 37
Granisetron Kabi (PK) *37*
Granisetron-AFT(AE) *37*
Granocyte 13(PF) *843*, *1079*
Granocyte 34(PF) *843*, *1079*
GRISEOFULVIN 162
Grisovin 500(QA) *162*
Grisovin(QA) *162*
Gynotril (ER) *303*
Haldol decanoate(JC) *616*
HALOPERIDOL 18, 616
HALOPERIDOL DECANOATE 616
Hamilton Skin Therapy Oil(KY) *1562*
Hamilton Skin Therapy Wash(KY) *1566*
Handy 36361414(BV) *1580*
Handy 71117-05(BV) *1589*
Handy 71117-06(BV) *1589*
Handygauze Cohesive 8631(BV)..... *1581*
Handygauze Cohesive 8633(BV)..... *1581*
Handygauze Cohesive 8635(BV)..... *1581*
Harvoni(GI) *235*, *236*, *833*, *834*, *1068*, *1069*
HCU Anamix infant(SB) *735*
HCU Anamix junior LQ(SB) *733*
HCU Anamix Junior(NU)..... *735*
HCU cooler 10(VF) *735*
HCU cooler 15(VF) *735*
HCU cooler 20(VF) *734*
HCU express 15(VF) *735*
HCU gel(VF) *735*
HCU Lophlex LQ 20(SB)..... *735*
HEPARIN SODIUM 84
Hepsera (GI) *1237*
Hequinel (RW) *564*
Herceptin SC(RO)..... *244*, *245*, *246*
Herron ClearLax(ON)..... *45*, *750*
HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE 743, 744
Hiprex(IA)..... *222*
HONEY BEE VENOM..... 707
Hospira Cefazolin Sodium (PF) *209*
Hospira Ceftriaxone(PF) *212*
Hospira Pty Limited (PF)..... *19*, *193*
Hospira Pty Limited(PF)
.Highly Specialised Drugs Program (Private Hospital)*827*, *828*, *994*
.Highly Specialised Drugs Program (Public Hospital)*1063*, *1230*
.Prescriber Bag *19*, *21*
Hospira Pty Limited(PF)
.ALIMENTARY TRACT AND METABOLISM *43*
Hospira Pty Limited(PF)
.BLOOD AND BLOOD FORMING ORGANS *84*
Hospira Pty Limited(PF)
.BLOOD AND BLOOD FORMING ORGANS *84*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *205*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *205*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *209*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *210*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *211*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *211*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *211*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *211*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *217*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *220*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *220*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *221*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *221*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *221*
Hospira Pty Limited(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *221*
Hospira Pty Limited(PF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *241*
Hospira Pty Limited(PF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *241*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *578*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *578*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *578*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *579*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *579*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *579*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *580*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *632*
Hospira Pty Limited(PF)
.NERVOUS SYSTEM *633*
Hospira Pty Limited(PF)
.RESPIRATORY SYSTEM *677*
HPMC PAA(NM).....*702*, *703*
Humalog KwikPen (KP).....*54*
Humalog Mix25 KwikPen (KP) *55*

Humalog Mix25(LY) *55*
Humalog Mix50 KwikPen (KP) *55*
Humalog Mix50(LY) *55*
Humalog(LY) *54*
HUMAN CHORIONIC GONADOTROPHIN 185, 1539
HUMAN MENOPAUSAL GONADOTROPHIN 1539
Humatrope(LY) *1302*, *1414*, *1452*
Humira(VE) *326*, *327*, *329*, *332*, *334*, *335*, *337*, *339*, *343*, *346*, *351*, *353*, *355*, *356*, *358*, *362*, *363*, *367*, *371*, *374*, *378*, *381*, *385*, *391*, *882*, *1118*
Humulin 30/70(LY) *55*
Humulin NPH(LY) *55*
Humulin R (LY) *54*
Hycor(QA) *681*
Hydopa(AF) *105*
HYDRALAZINE 106
Hydrea(BQ) *290*
Hydrene 25/50(AF) *108*
HYDROCHLOROTHIAZIDE 106
HYDROCHLOROTHIAZIDE + TRIAMTERENE 108
Hydrocoll 900744(HR) *1593*
Hydrocoll 900936(HR) *1592*
Hydrocoll Thin 900758(HR) *1592*
HYDROCORTISONE 193
HYDROCORTISONE ACETATE
.ALIMENTARY TRACT AND METABOLISM 49
.DERMATOLOGICALS 164
.Repatriation Pharmaceutical Benefits Scheme 1564
.SENSORY ORGANS 681
HYDROCORTISONE SODIUM SUCCINATE 19, 193
HYDROMORPHONE 577, 578
Hydrosorb 900854(HR) *1595*
Hydroxo-B12(AS) *99*
HYDROXOCOBALAMIN 99, 1559
HYDROXYCARBAMIDE (HYDROXYUREA) 290
HYDROXYCHLOROQUINE 564
Hydroxychloroquine AN(EA) *564*
Hydroxychloroquine GH (GQ) *564*
Hydroxychloroquine RBX(RA) *564*
Hygroton 25(GH) *107*
Hylo-Forte(AE) *706*
Hylo-Fresh(AE) *706*
Hymenoptera Honey Bee Venom(DE) *707*
HYOSCINE BUTYLBROMIDE 19, 749, 1554
HYOSCINE BUTYLBROMIDE SXP (XC) *19*, *749*
Hypnodorm(AF) *1575*
HYPROMELLOSE 702
HYPROMELLOSE + CARBOMER-980 702
Hypurin Isophane(AS) *54*
Hypurin Neutral(AS) *54*
Hysone 20(AF) *193*
Hysone 4(AF) *193*
IBANDRONATE 568, 968, 1204
Ibavyr(IX) *232*, *233*, *831*, *1066*
Ibilex 125 (AF) *208*
Ibilex 250 (AF) *208*
Ibilex 250(AF) *208*
Ibilex 500 (AF) *207*, *208*
IBRUTINIB 259
IBUPROFEN 561, 752
ICATIBANT 100
ICHTHAMMOL 1565
ICHTHAMMOL + ZINC OXIDE 1565
Iclusig(TS) *282*, *283*
Idaprex 2 (SZ) *116*
Idaprex 4 (SZ) *117*
Idaprex 8 (SZ) *117*
Idaprex Combi 4/1.25(SZ) *120*
IDARUBICIN 242
IDELALISIB 290, 291
Ikorel(SW) *104*
Ikotab (QA) *104*
ILOPROST 792, 1027
IMATINIB 259, 260, 262, 263, 264, 266, 268, 269
IMATINIB AN(EA) ... *261*, *262*, *263*, *264*, *265*, *268*, *269*, *270*
Imatinib GH (GQ) *261*, *262*, *263*, *264*, *265*, *268*, *269*, *270*
IMATINIB RBX (RA) *261*, *262*, *263*, *265*, *268*, *269*, *270*
Imatinib-APOTEX (TX) .. *261*, *262*, *263*, *264*, *265*, *268*, *269*, *270*
IMATINIB-DRLA(RZ) *261*, *262*, *263*, *264*, *265*, *268*, *269*, *270*
Imatinib-Teva(TB) *261*, *262*, *263*, *268*, *269*, *270*
Imazan (ER) *556*
Imbruvica(JC) *259*
Imdur 120 mg(AP) *104*
Imdur Durule(AP) *104*
Imigran FDT(AS) *597*
Imigran(AS) *597*
Imigran(LN) *596*, *597*
IMIPRAMINE 636
IMIQUIMOD 176, 1565, 1566
Imodium(JT) *48*
Imovane(SW) *1575*
Implanon NXT(MK) *179*
Imrest(AF) *1575*
Imukin(BY) *847*, *1084*
Imuran (AS) *556*
Imuran(AS) *556*
In a Wink Moisturising(NM) *702*
Inadine(KI) *1597*
INCOBOTULINUMTOXINA 1259, 1260
Incruse Ellipta(GK) *674*
INDACATEROL 665
INDACATEROL + GLYCOPYRRONIUM 670
INDAPAMIDE 107
INDAPAMIDE AN SR(EA) *107*
Indapamide AN(EA) *107*
Indapamide Sandoz (SZ) *107*
Inderal(AP) *109*
INDINAVIR 1235
Indocid(AS) *559*, *752*
INDOMETACIN 559, 751
Indosyl Combi 4/1.25 (RW) *120*
Indosyl Mono 2(RW) *116*
Indosyl Mono 4(RW) *117*
Indosyl Mono 8(RW) *117*
Inflectra(PF) ... *889*, *893*, *897*, *902*, *907*, *912*, *916*, *920*, *928*, *1125*, *1129*, *1133*, *1138*, *1143*, *1147*, *1152*, *1157*, *1164*
INFLIXIMAB .. 888, 889, 893, 897, 902, 907, 912, 916, 920, 1125, 1129, 1133, 1138, 1143, 1147, 1152, 1157, 1570
INGENOL MEBUTATE 1563, 1564
Inlyta(PF) *247*, *248*
iNova Pharmaceuticals (Australia) Pty Ltd(IA) *661*
Inpler(AF) *108*
Insig(RW) *107*
Inspra (PF) *108*
INSULIN ASPART 54
INSULIN ASPART + INSULIN ASPART PROTAMINE 55
INSULIN DETEMIR 55
INSULIN GLARGINE 55
INSULIN GLULISINE 54
INSULIN ISOPHANE BOVINE 54
INSULIN ISOPHANE HUMAN 55
INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL HUMAN 55
INSULIN LISPRO 54
INSULIN LISPRO + INSULIN LISPRO PROTAMINE 55
INSULIN NEUTRAL BOVINE 54
INSULIN NEUTRAL HUMAN 54
Intal CFC-Free(SW) *674*

Intal Forte CFC-Free(SW) *674*
Integrilin(MK) *89*
Intelence(JC) *1242*
INTERFERON ALFA-2A 304, 846, 1083, 1250
INTERFERON ALFA-2B 304, 305, 847, 1083, 1250
INTERFERON BETA-1A 305
INTERFERON BETA-1B 306
INTERFERON GAMMA-1B 847, 1083
Intrasite Gel 7313(SN) *1594*
Intron A Redipen(MK) *305*, *847*, *1083*, *1250*, *1251*
Intron A(MK) *847*, *1083*, *1250*, *1251*
Invega Sustenna(JC) *626*
Invega Trinza(JC) *626*, *627*
Invega(JC) *626*
Invirase(RO) *1236*
Inza 250(AF) *562*, *563*, *752*
Inza 500(AF) *562*, *563*, *752*
Iodosorb 66051330(SN) *1584*
Iodosorb 66051340(SN) *1584*
Iodosorb 66051360(SN) *1584*
Iodosorb Ointment 66051230(SN) *1584*
Iodosorb Ointment 66051240(SN) *1584*
Iodosorb Powder 66051070(SN) *1584*
Ionil-T(GA) *1565*
Iopidine 0.5%(NV) *682*
I-Pantoprazole(CR) *34*
Ipratrin Adult(AF) *673*
Ipratrin(AF) *673*
IPRATROPIUM
.Repatriation Pharmaceutical Benefits Scheme 1577
.RESPIRATORY SYSTEM 673
Iptam(AL) *596*, *597*
IRBESARTAN 123
IRBESARTAN + HYDROCHLOROTHIAZIDE 125
Irbesartan Actavis 150(ED) *123*
Irbesartan Actavis 300(ED) *123*
Irbesartan Actavis 75(ED) *123*
Irbesartan AMNEAL (EF) *123*
Irbesartan AN(EA) *123*
Irbesartan GH (GQ) *123*
Irbesartan HCT Actavis 150/12.5(ED) *126*
Irbesartan HCT Actavis 300/12.5(ED) *126*
Irbesartan HCT Actavis 300/25(ED) *126*
Irbesartan HCT GH 150/12.5 (GQ) *126*
Irbesartan HCT GH 300/12.5 (GQ) *126*
Irbesartan HCT GH 300/25 (GQ) *126*
Irbesartan HCTZ AMNEAL (EF) *126*
Irbesartan RBX(RA) *123*
Irbesartan Sandoz (SZ) *123*
Irbesartan Sandoz(SZ) *123*
Irbesartan/HCT Sandoz(SZ) *126*
Irbesartan/HCTZ RBX 150/12.5(RA) *126*
Irbesartan/HCTZ RBX 300/25(RA) *126*
Ircal(PE) *703*, *704*
Iressa(AP) *259*
IRON 98
IRON POLYMALTOSE 98
IRON SUCROSE 98
Irprestan 150(ZP) *123*
Irprestan 300(ZP) *123*
Irprestan 75 (ZP) *123*
Iscover (AV) *87*
Iscover(AV) *1559*
Isentress HD(MK) *1249*
Isentress(MK) *1249*
Isoleucine 1000(VF) *744*
Isoleucine 50(VF) *744*
ISOLEUCINE WITH CARBOHYDRATE 744
Isomonit (SZ) *104*
ISONIAZID 228
Isoptin 180 SR(GO) *114*
Isoptin SR(GO) *114*
Isoptin(GO) *114*
Isopto Carpine(NV) *683*
Isordil Sublingual(RW) *104*
Isosorbide AN(EA) *104*
ISOSORBIDE DINITRATE 104
ISOSORBIDE MONONITRATE 104
ISOTRETINOIN 174
Isotretinoin AN(EA) *174*, *175*
Isotretinoin SCP 20 (CR) *175*
Itracap (AF) *225*
ITRACONAZOLE 225
ITRANOX(RW) *225*
IVABRADINE 105
IVACAFTOR 989, 990, 1225, 1227
IVERMECTIN 664
IXEKIZUMAB 492, 497
Jakavi(NV) *284*, *285*
Janumet XR(MK) *66*
Janumet(MK) *66*
Januvia(MK) *73*
Jardiamet 12.5 mg/1000 mg(BY) *60*, *61*
Jardiamet 12.5 mg/500 mg(BY) *60*, *61*
Jardiamet 5 mg/1000 mg(BY) *60*, *61*
Jardiamet 5 mg/500 mg(BY) *60*, *61*
Jardiance(BY) *79*
Jelonet 7404(SN) *1590*
Jetrea(NV) *703*
JJ 12010(JJ) *1597*
Jurnista(JC) *578*
Kaletra(VE) *1246*
Kalixocin (AF) *214*
Kalma 0.25 (AF) *632*
Kalma 0.25(AF) *631*
Kalma 0.5 (AF) *631*
Kalma 1 (AF) *631*
Kaltostat 168117(CC) *1585*
Kaltostat 168210(CC) *1585*
Kaltostat 168212(CC) *1585*
Kalydeco(VR) *990*, *993*, *1227*, *1229*
Kapanol(YN) *581*, *582*
Kaptan (ER) *623*, *624*
Karlor CD(LN) *210*
Karvea (SW) *123*
Karvezide 150/12.5 (SW) *126*
Karvezide 300/12.5 (SW) *126*
Karvezide 300/25 (SW) *126*
Keflex(AS) *207*, *208*
Keflor CD (AF) *210*
Keflor(AF) *210*
Kenacomb Otic(QA) *707*
Kenacort-A10(QA) *195*
Keppra (UC) *605*, *606*
Kerron 1000(DO) *605*
Kerron 250(DO) *605*
Kerron 500(DO) *606*
Kerron(DO) *606*
KetoCal 3
1(SB) *744*
KetoCal 4
1 LQ(SB) *744*
1(SB) *744*
KETOCONAZOLE 161, 1560
Keto-Diastix(BN) *711*
KETOPROFEN 561
Kevtam 1000 (AF) *605*
Kevtam 250 (AF) *605*
Kevtam 500 (AF) *606*
Keyo(VF) *743*

keyomega(VF) *740*
Kindergen(SB) *747*
Kineret(FK) *928*, *1164*
Kinson(AF) *610*
Kivexa(VI) *1243*
Klacid(GO) *214*
Kombiglyze XR 2.5/1000(AP) *65*
Kombiglyze XR 5/1000(AP) *65*
Kombiglyze XR 5/500(AP) *64*
Konakion MM(RO) *21*
Kosteo (RW)
.ALIMENTARY TRACT AND METABOLISM *79*
.MUSCULO-SKELETAL SYSTEM *574*
KSART HCT 150/12.5 (RW) *126*
KSART HCT 300/12.5(RW) *126*
KSART HCT 300/25 (RW) *126*
Kuvan(IO) *82*
Kytril(IX) *37*
LABETALOL 112
LACOSAMIDE 603, 604
Lamictal(AS) *605*
Lamisil (Novartis Pharmaceuticals Australia Pty Limited) (NV) *1561*
Lamisil (Novartis Pharmaceuticals Australia Pty Limited)(NV) *162*, *163*
Lamisil DermGel(GK) *1561*
Lamisil(GK) *162*, *1561*
LAMITAN (RF) *605*
LAMIVUDINE 1238, 1239
LAMIVUDINE + ZIDOVUDINE 1245
Lamivudine 150 mg + Zidovudine 300 mg Alphapharm (AF) *1246*
Lamivudine Alphapharm (AF) *1239*
LAMOTRIGINE 604
Lamotrigine AN(EA) *605*
Lamotrigine Aspen 100 (RW) *605*
Lamotrigine Aspen 200 (RW) *605*
Lamotrigine Aspen 25 (RW) *605*
Lamotrigine Aspen 5 (RW) *605*
Lamotrigine Aspen 50 (RW) *605*
Lamotrigine generichealth(HQ) *605*
Lamotrigine GH (GQ) *605*
Lamotrigine GH(GQ) *605*
Lamotrigine Sandoz (SZ) *605*
Lamotrigine Sandoz(SZ) *605*
Lanoxin(QA) *100*, *101*
Lanoxin-PG(QA) *101*
Lanpro(JU) *687*
LANREOTIDE 825, 826, 1060, 1061
LANSOPRAZOLE 32
Lansoprazole ODT GH (GQ) *32*
LANTHANUM 708, 994, 1231
Lantim (JU) *687*, *688*
Lantus SoloStar (AV) *55*
Lantus(SW) *55*
Lanvis(AS) *241*
Lanzopran (RA) *32*
LAPATINIB 271
Largactil(SW) *18*, *615*
Lasix(SW) *19*, *107*
Lasix-M(SW) *107*
LATANOPROST 687
LATANOPROST + TIMOLOL 687
Latanoprost Actavis (EA) *687*
Latanoprost GH(GQ) *687*
Latanoprost Sandoz (SZ) *687*
Latanoprost/timolol AN 50/5(EA) *687*, *688*
Latanoprost/Timolol Sandoz 50/5 (SZ) *687*, *688*
Latuda(SE) *617*
LaxaCon(EA) *46*, *750*
lax-sachets (AE) *46*, *750*
Lax-Tab(AE) *44*, *749*
Ledip (RA) *113*
LEDIPASVIR + SOFOSBUVIR ... 235, 236, 833, 1068, 1069
LEFLUNOMIDE 316
Leflunomide AN (EA) *316*
Leflunomide APOTEX (GX) *316*
Leflunomide APOTEX(GX) *316*
Leflunomide GH (GQ) *316*
Leflunomide Sandoz(SZ) *316*
Lemtrada(GZ) *854*, *855*, *1090*, *1091*
LENALIDOMIDE 957, 958, 960, 1193, 1194, 1196
Lenest 30 ED (AF) *178*
Lengout(LN) *567*
LENOGRASTIM 842, 1078
LENVATINIB 271
Lenvima(EI) *272*
Lercadip(EA) *113*
Lercan (RW) *113*
LERCANIDIPINE 113
LERCANIDIPINE + ENALAPRIL 120
Lercanidipine GH(GQ) *113*
Lercanidipine Sandoz (SZ) *113*
Lescol XL(NV) *132*
Letroz(JU) *303*
LETROZOLE 303
Letrozole AN (EA) *303*
Letrozole FBM(FO) *303*
Letrozole generichealth (GQ) *303*
Letrozole RBX(RA) *303*
Letrozole Sandoz (SZ) *303*
Leucovorin Calcium (Hospira Pty Limited) (PF) *709*
Leucovorin Calcium (Hospira Pty Limited)(PF) *710*
Leucovorin Calcium (Pfizer Australia Pty Ltd)(PF) *710*
Leukeran(AS) *238*
Leukoflex 1124(BV) *1597*
Leukoplast 01071-00(BV) *1597*
Leukoplast 01072-00(BV) *1597*
Leukoplast 01073-00(BV) *1597*
Leukopor 2471(BV) *1598*
Leukopor 2472(BV) *1598*
Leukopor 2474(BV) *1597*
Leukosilk 1021(BV) *1598*
Leukosilk 1022(BV) *1598*
Leukosilk 1024(BV) *1597*
LEUPRORELIN 297, 298
LEUPRORELIN (&) INERT SUBSTANCE (&) BICALUTAMIDE
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 298, 301
Levactam(ER) *605*, *606*
Levecetam 1000 (RZ) *605*
Levecetam 250 (RZ) *605*
Levecetam 500 (RZ) *606*
Levemir FlexPen(NF) *55*
Levemir Penfill (NO) *55*
LEVETIRACETAM 605, 606
Levetiracetam AN(EA) *605*, *606*
Levetiracetam GH (GQ) *605*, *606*
Levetiracetam SZ(SZ) *605*, *606*
Levetiracetam-AFT (AE) *606*
Levi 1000 (RW) *605*
Levi 250 (RW) *606*
Levi 500 (RW) *606*
Levitaccord(RA) *605*
Levitra(BN) *1568*
Levlen ED(SY) *178*
LEVOCABASTINE
.Repatriation Pharmaceutical Benefits Scheme 1577, 1579

LEVODOPA + BENSERAZIDE 609
LEVODOPA + CARBIDOPA ANHYDROUS 610, 969, 1206
LEVODOPA + CARBIDOPA ANHYDROUS + ENTACAPONE 611
LEVONORGESTREL
.GENITO URINARY SYSTEM AND SEX HORMONES 176, 179
LEVONORGESTREL + ETHINYLESTRADIOL
.GENITO URINARY SYSTEM AND SEX HORMONES 178, 179
Lexam 10 (RW) *637*
Lexam 20 (RW) *638*
Lexapro(LU) *637*, *638*, *639*
Lexotan(RO) *1575*
LIGHT LIQUID PARAFFIN + COCOAMPHODIACETATE DISODIUM 1566
LIGNOCAINE
.CARDIOVASCULAR SYSTEM 101
.Prescriber Bag 20
.Repatriation Pharmaceutical Benefits Scheme 1563
LINAGLIPTIN 70
LINAGLIPTIN + METFORMIN 61
Lincocin(PF) *217*
LINCOMYCIN 217
Link Medical Products Pty Ltd(LM)
.Prescriber Bag *18*
Link Medical Products Pty Ltd(LM)
.CARDIOVASCULAR SYSTEM *102*
Link Medical Products Pty Ltd(LM)
.CARDIOVASCULAR SYSTEM *102*
Link Medical Products Pty Ltd(LM)
.DERMATOLOGICALS *176*
Link Medical Products Pty Ltd(LM)
.DERMATOLOGICALS *176*
Link Medical Products Pty Ltd(LM)
.ANTIINFECTIVES FOR SYSTEMIC USE *228*
Link Medical Products Pty Ltd(LM)
.ANTIINFECTIVES FOR SYSTEMIC USE *228*
Link Medical Products Pty Ltd(LM)
.RESPIRATORY SYSTEM *674*
Link Medical Products Pty Ltd(LM)
.RESPIRATORY SYSTEM *674*
Lioresal 10 (NV) *565*
Lioresal 25 (NV) *565*
Lioresal Intrathecal (NV) *968*, *1204*
LIOTHYRONINE 195
LIPEGFILGRASTIM 843, 1079
Lipex 10(FR) *138*, *139*
Lipex 20(FR) *138*, *139*
Lipex 40(FR) *138*, *139*
Lipex 80(FR) *138*
Lipidil(GO) *139*, *140*
Lipigem (AF) *140*
Lipistart(VF) *726*, *727*
Lipitor(PF) *131*, *132*
Liposomal Doxorubicin SUN (RA) *838*, *1073*
Lipostat 10 (RF) *133*
Lipostat 20 (RF) *133*
Lipostat 40 (RF) *133*, *134*
Lipostat 80 (RF) *133*, *134*
Liquifilm Tears(AG) *705*
Liquigen(SB) *712*
LISDEXAMFETAMINE 647
LISINOPRIL 116
Lisinopril AN(EA) *116*
Lisinopril generichealth (GQ) *116*
Lisinopril Sandoz(SZ) *116*
Lithicarb(AS) *642*
LITHIUM CARBONATE 642
Livostin(JT)
.Repatriation Pharmaceutical Benefits Scheme *1577*, *1579*
Locasol(SB) *733*
Loceryl(GA) *1561*
Lodam SR 100(ZP) *591*
Lodam SR 150(ZP) *591*
Lofenoxal(IA) *48*
Logem (AL) *605*
Logem(AL) *605*
Logicin Rapid Relief(QA) *1576*
Logicin Sinus(QA) *1577*
Logynon ED(SY) *179*
Lomotil(IV) *48*
Loniten(PF) *106*
Lonquex(TB) *845*, *1081*
LOPERAMIDE 48, 1556
LOPINAVIR + RITONAVIR 1246
Lopresor 100(NV) *111*
Lopresor 50(NV) *111*
Lorano(SZ) *1578*
LORATADINE 1578
Lorstat 10 (AF) *131*, *132*
Lorstat 20 (AF) *131*, *132*
Lorstat 40 (AF) *131*, *132*
Lorstat 80 (AF) *131*, *132*
LOSARTAN 123
Losec Tablets(AP) *33*
Lovan 20 Tab(AL) *639*
Lovan(AL) *639*
Lovir(EA) *229*
LoxaLate(AF) *637*, *638*
Loxip 500 (DO) *219*
Loxip 750(DO) *219*
Lozanoc(YN) *225*
LPV (IA) *203*, *204*
LUBRICATING AGENT 1580
Lubri-Gel(PP) *1580*
Lucentis(NV) *692*, *693*, *695*, *697*
Lucrin Depot 3 Month PDS(VE) *298*
Lucrin Depot 4 Month PDS(VE) *297*
Lucrin Depot 6-Month(VE) *297*
Lucrin Depot 7.5mg PDS(VE) *298*
Lucrin Depot Paediatric 30 mg PDS(VE) *297*, *298*
Lukair (AL) *676*
Lumigan PF(AG) *686*
Lumigan(AG) *686*
Lumin 10(AF) *643*
Lumin 20(AF) *643*
Lunava 10 (ZP) *316*
Lunava 20 (ZP) *316*
LURASIDONE 617
LUTROPIN ALFA 1539
Luveris(SG) *1540*
Luvox(GO) *639*, *640*
Lycinate(RF) *103*
Lyclear(JT) *664*
Lynparza(AP) *293*
LYPRALIN(RW) *594*
Lyrica (PF) *594*
Lyzalon(AF) *594*
Mabthera SC(RO) *243*
Mabthera(RO)
.Highly Specialised Drugs Program (Private Hospital) *839*, *966*
.Highly Specialised Drugs Program (Public Hospital) *1074*, *1203*
MACITENTAN 797, 1032
Macrodantin(PF) *222*
MACROGOL-3350 ..... 45, 750

MACROGOL-3350 + SODIUM CHLORIDE + BICARBONATE + POTASSIUM CHLORIDE 45, 750
Macrovic(RF) *46*, *750*
Madopar 125(RO) *609*, *610*
Madopar 62.5(RO) *610*
Madopar HBS(RO) *610*
Madopar Rapid 125(RO) *610*
Madopar Rapid 62.5(RO) *610*
Madopar(RO) *610*
Magicul 400(AF) *29*
MagMin (PBS)(BB) *80*
Magmin(BB) *1558*
MAGNESIUM ASPARTATE DIHYDRATE 80, 1558
Mag-Sup (PP) *80*
Mag-Sup(PP) *1558*
Malarone(GK) *662*
Malean (RW) *115*
MANNITOL 988, 1224
MARAVIROC 1248
Marevan (FM) *82*
Marevan(FM) *82*
MassBiologics tetanus and diphtheria toxoids adsorbed(CS) *19*, *238*
Maxalt(AL) *596*
Maxamox(SZ) *201*, *202*
MAXATAN(RW) *596*
Maxidex(NV) *679*
Maxolon(IA) *20*, *36*, *749*
Maxor (AF) *33*, *34*
Mayne Pharma Doxycycline(YT) *198*, *199*, *200*
Mayne Pharma Erythromycin(YT) *215*
Mayne Pharma Oxycodone IR (YN) *582*, *583*
MCT Oil(SB) *712*
MCT Pro-Cal(VF) *746*
MEBENDAZOLE 1576
MEBEVERINE 1554
Medipore 2961(MM) *1597*
MEDIUM CHAIN TRIGLYCERIDES 711, 712
MEDROXYPROGESTERONE
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 295, 296
.GENITO URINARY SYSTEM AND SEX HORMONES 179, 183
MEFENAMIC ACID 563
Mefix 310250(MH) *1597*
Megafol 0.5 (AF) *99*, *1560*
Megafol 5(AF) *99*, *1560*
Mekinist(NV) *289*
Melizide(AF) *57*
Melolin 36361357(SN) *1596*
Melolin 66974933(SN) *1596*
Meloxiauro 15(DO) *560*
Meloxiauro 7.5(DO) *560*
Meloxibell (GQ) *560*
MELOXICAM 559
Meloxicam AN(EA) *560*
Meloxicam Ranbaxy(RA) *560*
Meloxicam Sandoz (SZ) *560*
Meloxicam Sandoz(SZ) *560*
Meloxicam-GA (ED) *560*
MELPHALAN 239
MEMANTINE 655
Memantine generichealth(GQ) *655*, *656*
Memanxa (RW) *655*, *656*
Menopur 1200(FP) *1539*
Menopur 600(FP) *1539*
Mepilex 294100(MH) *1589*
Mepilex Ag(MH) *1588*
Mepilex Border 295200(MH) *1588*
Mepilex Border 295300(MH) *1588*
Mepilex Border Ag(MH) *1588*
Mepilex Lite 284000(MH) *1588*
Mepilex Lite 284100(MH) *1588*
Mepitac 298300(MH) *1598*
Mepitac 298400(MH) *1598*
Mepitel 290510(MH) *1595*
Mepitel 290710(MH) *1595*
MEPOLIZUMAB 970, 972, 1207, 1209
Meprazol(SZ) *33*
MERCAPTOPURINE 241
MESALAZINE 50, 51
Mesasal(AS) *51*
MESNA 710
Mestinon Timespan(IA) *656*
Mestinon(IA) *656*
Metalyse(BY) *90*
Metamucil Natural Granular(PY) *1556*
Metamucil Orange Smooth(PY) *1555*
METEX XR 1000(RW) *56*
Metex XR(RW) *56*
METFORMIN 55
METFORMIN + GLIBENCLAMIDE 63
Metformin 500(CR) *56*
Metformin 850(CR) *56*
Metformin AN (EA) *56*
Metformin generichealth 1000(GQ) *56*
Metformin generichealth(GQ) *56*
Metformin Ranbaxy 1000 (RA) *56*
Metformin Sandoz (SZ) *56*
Metformin Sandoz(SZ) *56*
Metformin XR 500 APOTEX (GX) *56*
METHADONE
.NERVOUS SYSTEM 588
.Opiate Dependence Treatment Program 1543
.Palliative Care 757
METHENAMINE HIPPURATE 222
Methoblastin(PF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *241*, *556*
Methopt(QA) *702*
METHOTREXATE
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 241, 556
Methotrexate Accord(OD) *241*
METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA 771, 1007
METHOXYFLURANE 20
METHYL SALICYLATE 1571
METHYLDOPA 105
METHYLNALTREXONE 751
METHYLPHENIDATE 647, 648
Methylpred(AL) *194*
METHYLPREDNISOLONE
.DERMATOLOGICALS 168, 169, 170, 171
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 194
Methylprednisolone Alphapharm (AF) *194*
METOCLOPRAMIDE 20, 36, 749
Metoclopramide AN(EA) *36*
Metoclopramide RBX (RA) *36*
Metoprolol AN(EA) *111*
Metoprolol RBX (RA) *111*
Metoprolol Sandoz(SZ) *111*
METOPROLOL SUCCINATE 110
METOPROLOL TARTRATE 111
Metrogyl 200(AF) *222*
Metrogyl 400(AF) *222*
Metrol 100 (RW) *111*
Metrol 50 (RW) *111*
Metrol-XL 190(RW) *111*

Metrol-XL 23.75(RW) *111*
Metrol-XL 47.5(RW) *111*
Metrol-XL 95(RW) *111*
METRONIDAZOLE 221, 222
Metronide 200 (AV) *222*
Metronide 400 (AV) *222*
Mezavant(ZI) *50*
Miacalcic 100(NV) *198*
MIANSERIN 642
Micardis Plus 40/12.5 mg(BY) *127*
Micardis Plus 80/12.5 mg(BY) *127*
Micardis Plus 80/25 mg(BY) *127*
Micardis(BY) *124*
Micolette(AE) *47*, *751*, *1556*
MICONAZOLE 161, 1561
Microdacyn(TF) *1597*
Microgynon 50 ED(BN) *178*
Microlut 28(BN) *179*
Micronelle 30 ED(TX) *178*
MIDAZOLAM 20
MIFEPRISTONE (&) MISOPROSTOL 187
Milivin OD 15(DO) *643*
Milivin OD 30(DO) *643*
Milivin OD 45(DO) *643*
MILK POWDER LACTOSE FREE FORMULA PREDIGESTED 732
MILK POWDER LACTOSE INTOLERANCE FORMULA 732
MILK POWDER SYNTHETIC LOW CALCIUM 733
MILK PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE 744
Minax 100(AF) *111*
Minax 50(AF) *111*
Minax XL (AF) *111*
Minidiab(PF) *57*
Minipress(PF) *106*
Minirin Melt(FP) *191*
Minirin Nasal Spray(FP) *190*, *191*
Minirin(FP) *190*
Minitran 10(IA) *103*
Minitran 15(IA) *104*
Minitran 5(IA) *103*
MINOCYCLINE 200
Minomycin-50(QA) *200*
MINOXIDIL 106
Mircera(RO) *772*, *1007*
Mirena(BN) *176*
MIRTANZA(RF) *643*
MIRTAZAPINE 643
Mirtazapine AN (EA) *643*
Mirtazapine AN ODT (EA) *643*
Mirtazapine GH(GQ) *643*
Mirtazapine Sandoz (SZ) *643*
Mirtazapine Sandoz ODT 15(SZ) *643*
Mirtazapine Sandoz ODT 30(SZ) *643*
Mirtazapine Sandoz ODT 45(SZ) *643*
Mirtazon(RW) *643*
Mistrom(ER) *111*
Mixtard 30/70 InnoLet (NI) *55*
Mixtard 30/70 Penfill 3 mL(NO) *55*
Mixtard 50/50 Penfill 3 mL(NO) *55*
Mizart (AF) *124*
Mizart HCT 40/12.5 mg (AF) *127*
Mizart HCT 80/12.5 mg (AF) *127*
Mizart HCT 80/25 mg (AF) *127*
MMA/PA Anamix infant(SB) *736*
MMA/PA Anamix Junior(NU) *736*
MMA/PA cooler 15(VF) *736*
MMA/PA express 15(VF) *735*
MMA/PA gel(VF) *735*
Mobic(BY) *560*
Mobilis 10 (AF) *561*
Mobilis 20 (AF) *560*, *561*
Mobilis D-10(AF) *560*
Mobilis D-20(AF) *561*
MOCLOBEMIDE 641
Moclobemide AN (EA) *641*
Moclobemide Sandoz(SZ) *641*
Modafin (RW) *649*
MODAFINIL 648
Modafinil AN(EA) *649*
Modafinil Mylan (AF) *649*
Modafinil Sandoz(SZ) *649*
Modavigil (TB) *649*
MODIFIED LONG CHAIN AMYLOPECTIN 727
Moduretic(AS) *108*
Mogadon(IA)
.Palliative Care *760*
Mogadon(IA)
.NERVOUS SYSTEM *599*, *634*
Mohexal (HX) *641*
Molaxole (HM) *46*, *750*
Momasone(QA) *171*, *172*, *173*
MOMETASONE 171, 172, 173, 1564
Momex SR 10(RW) *581*
Momex SR 100(RW) *581*
Momex SR 30(RW) *581*
Momex SR 60(RW) *581*
Monace 10(AF) *116*
Monace 20(AF) *116*
Monodur 120 mg(PM) *104*
Monodur 60 mg(PM) *104*
Monofeme 28(FZ) *178*
Monogen(SB) *726*, *727*
MONTELUKAST 675, 676
Montelukast AN(EA) *676*
Montelukast GH (GQ) *676*
Montelukast Sandoz 4(SZ) *676*
Montelukast Sandoz 5(SZ) *676*
MORPHINE 21, 578, 579, 580, 582, 753, 1573
Morphine Juno(JU) *21*, *578*, *579*, *580*
Morphine MR AN (EA) *581*
MORPHINE MR APOTEX(TX) *581*
Morphine MR Mylan (AF) *581*
Motilium(JC) *36*
Movalis 15 (RW) *560*
Movalis 15(RW) *560*
Movalis 7.5 (RW) *560*
Movalis 7.5(RW) *560*
Movapo PFS(TD) *970*, *1206*
Movapo(TD) *969*, *970*, *1206*
Movicol Liquid(NE) *46*, *750*
Movicol(NE) *46*, *750*
Movox 100(AF) *640*
Movox 50(AL) *639*
Moxicam 15 (AF) *560*
Moxicam 7.5 (AF) *560*
Moxicam(AF) *560*
Moxiclav Duo 500/125(QA) *206*, *207*
Moxiclav Duo Forte 875/125 (QA) *206*, *207*
MOXONIDINE 105
Mozobil(GZ) *848*, *1085*
MS Contin Suspension 100 mg(MF) *581*
MS Contin Suspension 20 mg(MF) *581*
MS Contin Suspension 200 mg(MF) *579*
MS Contin Suspension 30 mg(MF) *581*
MS Contin Suspension 60 mg(MF) *581*
MS Contin(MF) *579*, *581*, *582*, *753*, *1573*
MS Mono(MF) *581*, *582*
MS-2 Step(XH) *188*
MSUD AID III(SB) *739*

MSUD amino5(VF) *740*
MSUD Anamix infant(SB) *739*
MSUD Anamix Junior LQ(SB) *739*
MSUD Anamix Junior(SB) *739*
MSUD cooler 10(VF) *739*
MSUD cooler 15(VF) *738*
MSUD cooler 20(VF) *738*
MSUD express 15(VF) *739*
MSUD express 20(VF) *738*
MSUD gel(VF) *739*
MSUD Lophlex LQ 20(SB) *739*
MSUD Maxamum(SB) *738*
MUPIROCIN
.Repatriation Pharmaceutical Benefits Scheme 1563
.RESPIRATORY SYSTEM 665
Murelax(RW) *633*, *759*
MYCOBACTERIUM BOVIS (BACILLUS CALMETTE AND GUERIN (BCG)) TICE STRAIN 308
Mycobutin(PF) *830*, *1065*
Myconail(AE) *1561*
MYCOPHENOLATE 316, 317, 863, 864, 1099, 1100
Mycophenolate AN (EA) *316*, *863*, *1099*
Mycophenolate Sandoz(SZ) *316*, *317*, *863*, *864*, *1099*, *1100*
Mycostatin Oral Drops(QA) *1554*
Mycostatin(FM) *161*, *1560*
Myfortic(NV) *316*, *317*, *864*, *1100*
Mylanta Double Strength(JT) *1554*
Myleran(AS) *239*
Myocrisin(SW) *565*
Mysoline(LM) *598*
NADROPARIN 85
NAFARELIN 191, 1540
NALOXONE 21, 708
Naloxone Hydrochloride (DBL)(PF) *21*, *708*
Naloxone Juno (JU) *21*, *708*
NALTREXONE 660
Naltrexone GH (GQ) *660*
NANDROLONE DECANOATE 80
NAPHAZOLINE 1578
NAPHAZOLINE + ANTAZOLINE 1578
Naprosyn SR1000(IX) *562*, *563*, *752*
Naprosyn SR750(IX) *562*, *563*, *752*
Naprosyn(IX) *562*, *563*, *752*
NAPROXEN 562, 563, 752
Naramig(AS) *595*, *596*
NARATRIPTAN 595
NARCAN(PL) *21*
Nardil(LM) *641*
NATALIZUMAB 864, 1100
Natrilix SR(SE) *107*
Natrilix(SE) *107*
Navelbine(FB) *242*
Nebilet(FK) *111*
NEBIVOLOL 111
NEDOCROMIL 674
Neo-B12 (PF) *99*
Neo-B12(PF) *1559*
Neocate Advance Vanilla(SB) *714*, *716*
Neocate Advance(SB) *715*, *716*
Neocate Gold(SB) *719*, *721*
Neocate Junior(SB) *731*, *732*
Neocate LCP(SB) *717*, *718*
Neo-Mercazole (GH) *197*
Neoral 10(NV) *555*, *956*, *1192*
Neoral 100 (NV) *555*, *956*, *1192*
Neoral 25 (NV) *555*, *956*, *1192*
Neoral 50 (NV) *555*, *956*, *1192*
Neoral(NV) *555*, *956*, *1192*
NeoRecormon(RO) *770*, *771*, *1006*
Neotigason(UA) *164*
Nesina Met 12.5/1000(TK) *58*
Nesina Met 12.5/500(TK) *58*
Nesina Met 12.5/850(TK) *58*
Nesina(TK) *69*
NETUPITANT + PALONOSETRON 37
Neulactil(SW) *616*
Neulasta(AN) *846*, *1082*
Neupogen(AN) *842*, *1077*
Neupro(UC) *614*
Neuroccord (CR) *594*
Neurontin (PF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Neurontin (PF)
.NERVOUS SYSTEM *602*
Neurontin(PF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Neurontin(PF)
.NERVOUS SYSTEM *602*
NEVIRAPINE 1242
Nevirapine Alphapharm(AF) *1243*
Nevirapine XR APOTEX(TX) *1242*
Nexavar(BN) *285*, *286*
Nexazole(RW) *30*, *31*, *32*
Nexcare Durable Cloth First Aid Tape 799(MM) *1598*
Nexcare Gentle Paper First Aid Tape 789(MM) *1598*
Nexcare Tegaderm Transparent H1624(MM) *1586*
Nexcare Tegaderm Transparent H1626(MM) *1586*
Nexium (AP) *30*, *31*, *32*
Nexium Hp7(AP) *35*
Nexole(RF) *31*, *32*
Nicabate CQ 14(GC) *1576*
Nicabate CQ 21(GC) *1576*
Nicabate P(GC) *658*
NICORANDIL 104
nicorette 16hr Invisipatch(JT) *658*
Nicorette Patch(JT) *1576*
NICOTINE 657, 658, 1576
Nicotinell Step 1(ON) *657*, *658*
Nicotinell Step 2(ON) *657*
Nicotinell Step 3(ON) *657*
Nidem (RW) *57*
NIFEDIPINE 114
NILOTINIB 272, 274
Nilstat(QA)
.Repatriation Pharmaceutical Benefits Scheme *1566*
Nilstat(QA)
.ALIMENTARY TRACT AND METABOLISM *47*
NILUTAMIDE 302
NINTEDANIB 276
NITRAZEPAM
.NERVOUS SYSTEM 599, 634
.Palliative Care 760
Nitro-Dur 10(MK) *103*
Nitro-Dur 15(MK) *103*
Nitro-Dur 5(MK) *103*
NITROFURANTOIN 222
Nitrolingual Pumpspray(SW) *19*, *104*
Nitrostat(PF) *103*
Nivestim(PF) *841*, *842*, *1077*, *1078*
Nizac(RF) *30*
NIZATIDINE 30
Nizoral 1%(JT) *161*
Nizoral 2% Cream(JT) *161*
Nizoral 2%(JT) *161*
Nolvadex-D (AP) *300*
Nolvadex-D(AP) *299*
Nordette 28(PF) *178*
Nordip (AF) *113*
Norditropin FlexPro(NO) *1293*, *1294*, *1378*, *1471*
Norditropin SimpleXx(NO) *1293*, *1294*, *1378*, *1379*, *1471*

NORETHISTERONE
.GENITO URINARY SYSTEM AND SEX HORMONES 179, 183
NORETHISTERONE + ETHINYLESTRADIOL 178
NORETHISTERONE + MESTRANOL 179
NORETHISTERONE ACETATE + ESTRADIOL (&) ESTRADIOL 184
NORFLOXACIN 220
Noriday 28 Day(PF) *179*
Norimin 28 Day(FZ) *178*
Norimin-1 28 Day(FZ) *178*
Norinyl-1/28(PF) *179*
Normacol Plus(NE) *45*, *750*, *1556*
Normison(QA) *634*, *635*, *760*
Norprolac(FP) *178*
Norspan(MF) *589*, *758*
NORTRIPTYLINE 637
NortriTABS 10 mg (GH) *637*
NortriTABS 25 mg (GH) *637*
Norvapine(ED) *113*
Norvasc(PF) *113*
Norvir(VE) *1235*
Noten(AF) *110*
Novacodone(HX) *584*
Novasone (AF) *171*, *172*, *173*
Novatin (TX) *164*
Novicrit(SZ) *771*, *1006*
NovoMix 30 FlexPen(NF) *55*
NovoMix 30 Penfill 3 mL (NO) *55*
NovoRapid FlexPen(NF) *54*
NovoRapid Penfill 3 mL (NO) *54*
NovoRapid(NO) *54*
Noxafil(MK) *226*
Noxicid Caps (AL) *31*, *32*
Nplate(AN) *768*, *1003*
Nucala(GK) *972*, *975*, *1209*, *1212*
Nuelin(IA) *675*
Nuelin-SR 200(IA) *675*
Nuelin-SR 250(IA) *675*
Nuelin-SR 300(IA) *675*
Nufloxib (AF) *220*
Nu-Gel 2497(KI) *1595*
Nupentin 100 (AF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Nupentin 100 (AF)
.NERVOUS SYSTEM *602*
Nupentin 300 (AF)
.NERVOUS SYSTEM *602*
Nupentin 300(AF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Nupentin 400 (AF)
.NERVOUS SYSTEM *602*
Nupentin 400(AF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Nupentin Tabs (AF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Nupentin Tabs(AF)
.Repatriation Pharmaceutical Benefits Scheme *1574*
Nupentin Tabs(AF)
.NERVOUS SYSTEM *602*, *603*
Nutrini Peptisorb Energy(NU) *713*
Nutrini Peptisorb(SB) *726*
NutropinAq(IS) *1294*, *1379*, *1471*
Nuvigil(TB) *645*
Nyogel(AS) *685*, *686*
NYSTATIN
.ALIMENTARY TRACT AND METABOLISM 47
.DERMATOLOGICALS 161
.Repatriation Pharmaceutical Benefits Scheme 1554, 1560, 1566
O.R.S.(AS) *48*
OCRELIZUMAB 865, 1101
Ocrevus(RO) *865*, *1101*
OCRIPLASMIN 703
OCTREOTIDE 826, 827, 1061, 1062
Octreotide (SUN)(RA) *827*, *828*, *1063*
Octreotide MaxRx (GQ)
.Highly Specialised Drugs Program (Private Hospital) *827*, *828*
.Highly Specialised Drugs Program (Public Hospital) *1063*
Ocuflox(AG) *679*
Odaplix SR (AF) *107*
Odefsey(GI) *1245*
Ofev(BY) *277*
OFLOXACIN 679
Olanzacor 10(CR) *620*
Olanzacor 2.5(CR) *619*
Olanzacor 5(CR) *619*
Olanzacor 7.5(CR) *619*
OLANZAPINE 618, 619, 620, 621, 622
Olanzapine AN (EA) *619*, *620*
Olanzapine AN ODT (EA) *620*, *621*, *622*
Olanzapine generichealth 10(GQ) *620*
Olanzapine generichealth 2.5(GQ) *618*
Olanzapine generichealth 5(GQ) *619*
Olanzapine generichealth 7.5(GQ) *619*
Olanzapine ODT generichealth 10 (GQ) *621*
Olanzapine ODT generichealth 5 (GQ) *620*
Olanzapine ODT-DRLA(RZ) *620*, *621*
Olanzapine RBX (RA) *619*, *620*
Olanzapine Sandoz ODT 10(SZ) *621*
Olanzapine Sandoz ODT 15(SZ) *621*
Olanzapine Sandoz ODT 20(SZ) *622*
Olanzapine Sandoz ODT 5(SZ) *620*
Olanzapine Sandoz(SZ) *619*, *620*
Olanzapine-DRLA(RZ) *619*, *620*
OLAPARIB 292, 293
OLMERTAN (RW) *123*, *124*
OLMERTAN COMBI 20/12.5 (RW) *126*
OLMERTAN COMBI 40/12.5 (RW) *126*
OLMERTAN COMBI 40/25 (RW) *126*
Olmesartan - MYL (AF) *123*, *124*
OLMESARTAN + AMLODIPINE + HYDROCHLOROTHIAZIDE 130
Olmesartan AN(EA) *123*, *124*
Olmesartan HCT - MYL 20/12.5 (AF) *127*
Olmesartan HCT - MYL 40/12.5 (AF) *126*
Olmesartan HCT - MYL 40/25 (AF) *126*
Olmesartan HCT AN 20/12.5(EA) *127*
Olmesartan HCT AN 40/12.5(EA) *126*
Olmesartan HCT AN 40/25(EA) *126*
OLMESARTAN MEDOXOMIL 123
OLMESARTAN MEDOXOMIL + AMLODIPINE 128
OLMESARTAN MEDOXOMIL + HYDROCHLOROTHIAZIDE 126
Olmesartan Sandoz(SZ) *123*, *124*
Olmesartan/Amlodipine - MYL 20/5 (AF) *128*
Olmesartan/Amlodipine - MYL 40/10 (AF) *129*
Olmesartan/Amlodipine - MYL 40/5 (AF) *129*
Olmesartan/HCT Sandoz(SZ) *126*, *127*
Olmetec Plus (MK) *126*, *127*
Olmetec(MK) *124*
OLSALAZINE 52
OMALIZUMAB 975, 976, 977, 983, 1212, 1213, 1214, 1219
Omegapharm Pty Ltd(OE) *212*, *213*
Omepral (ZA) *33*
OMEPRAZOLE 33
Omeprazole AN (EA) *33*
Omeprazole generichealth(GQ) *33*
Omeprazole Sandoz(HX) *33*, *34*

Omeprazole Sandoz(SZ) *33*
Omnitrope Surepal 10(SZ) *1269*, *1361*, *1433*
Omnitrope Surepal 15(SZ) *1270*, *1361*, *1433*
Omnitrope Surepal 5(SZ) *1269*, *1361*, *1433*
Omnitrope(SZ) *1270*, *1361*, *1433*
Onbrez(NV) *665*
OncoTICE(MK) *308*
ONDANSETRON 38, 39, 40
Ondansetron Alphapharm(AF) *38*, *39*
Ondansetron AN (EA) *38*, *39*
Ondansetron AN ODT(EA) *39*, *40*
Ondansetron ODT GH(GQ) *39*, *40*
Ondansetron ODT-DRLA (RZ) *39*, *40*
Ondansetron SZ (HX) *38*, *39*
Ondansetron SZ ODT (HX) *39*, *40*
Ondansetron-DRLA(RZ) *38*, *39*
Onglyza(AP) *72*
Onsetron (ZP) *38*, *39*
Onsetron 4(ZP) *38*, *39*
Onsetron 8(ZP) *38*, *39*
Op-Site Flexigrid 4629(SN) *1586*
Opsumit(AT) *802*, *1037*
Optifresh eye gel(PP) *698*, *699*
Optifresh Plus(PP) *700*
Optifresh Tears(PP) *700*
Optive(AG) *700*, *701*
Orabase(QA) *1562*
Oratane (RF) *174*, *175*
Oratane(RF) *175*
Ordine 10(MF) *580*, *582*
Ordine 2(MF) *580*, *582*
Ordine 5(MF) *580*, *582*
Orencia ClickJect(BQ) *310*, *315*
Orencia(BQ) *310*, *315*, *854*, *1090*
Orgalutran(MK) *1540*
Orion Temozolomide (ON) *239*, *240*
Oripro(ON) *1537*
ORLISTAT 1556
Oroxine(QA) *196*
Orudis SR 200(SW) *562*
Oruvail SR(AV) *562*
OsmoLax(KY) *45*, *750*
Ospolot(PL) *607*
Osteomol 665 Paracetamol (CR) *594*, *758*
Osteomol 665 Paracetamol(CR) *594*, *758*, *1574*
Osteovan (SZ) *569*, *570*
Ostira(PF) *569*, *570*
Otocomb Otic(FM) *707*
Otodex(AV) *707*
Ovestin Ovula(AS) *183*
Ovestin(AS) *183*
Ovidrel(SG) *1537*
OXAZEPAM 633, 759
OXCARBAZEPINE 600
Oxis Turbuhaler(AP) *665*
OXPRENOLOL 109
OXYBUTYNIN 188
Oxybutynin Sandoz (SZ) *188*
OXYCODONE 582, 583, 584
OXYCODONE + NALOXONE 584
Oxycodone Aspen(FM) *583*
Oxycodone Sandoz (SZ) *584*
OxyContin(MF) *584*
OXYMETAZOLINE 1576
OxyNorm Liquid 1mg/mL(MF) *583*
OxyNorm(MF) *582*, *583*
OXYTOCIN 21
Oxytocin Sandoz(SZ) *21*
Oxytrol(GN) *188*
Ozidal (RA) *627*, *628*, *630*
Ozidal(RA) *629*, *631*
Ozin 10 (DO) *620*
Ozin 2.5 (DO) *619*
Ozin 5 (DO) *619*
Ozin 7.5 (DO) *620*
Ozin ODT 10 (DO) *621*
Ozin ODT 15 (DO) *621*
Ozin ODT 20 (DO) *622*
Ozin ODT 5 (DO) *620*
Ozlodip (RA) *113*
Ozmep (ZP) *33*
Ozole (RA) *223*
Ozole(RA) *223*
Ozpan (RA) *34*
Ozpan(RA) *34*
Ozurdex(AG) *681*
Ozvir (RA) *229*
PAA (IA) *698*, *699*
Pacrolim(AF) *555*, *556*, *956*, *957*, *1193*
Paediatric Seravit(SB) *747*
Palexia SR(CS) *590*
PALIPERIDONE 626
PALONOSETRON 40
PAMIDRONATE DISODIUM 568, 968, 1204, 1205
Pamisol(PF) *568*, *968*, *1205*
Panadeine Forte(SW) *589*, *590*
Panadol(GC) *758*
Panafcort(AS) *195*
Panafcortelone(AS) *194*
Panamax (SW) *593*, *1573*, *1574*
Panamax 240 Elixir(SW) *593*, *1573*
Panamax Co. 40(SW) *1573*
Panamax(SW) *593*
PANCREATIC EXTRACT 52, 53
PANCRELIPASE 53
PANTHENOL 1566
Panthron (ER) *34*
Panthron(ER) *34*
Panto (TK) *34*
Panto(TK) *34*
Pantofast 20 (RZ) *34*
Pantofast 40(RZ) *34*
PANTOPRAZOLE 34
Pantoprazole Actavis (ED) *34*
Pantoprazole AN(EA) *34*
Pantoprazole GH (GQ) *34*
Pantoprazole Sandoz(SZ) *34*
Panzytrat 25000(TM) *53*
PAPER WASP VENOM 708
PARACETAMOL 592, 593, 758, 1573, 1574
Paracetamol (Sandoz)(SZ) *593*, *1573*, *1574*
PARACETAMOL + CODEINE 589, 1573
Paracetamol/Codeine GH 500/30(GQ) *589*
PARAFFIN 703, 704
Paralgin (OW) *593*, *1573*, *1574*
Parapane(AF) *593*, *1573*, *1574*
Parbezol (RW) *35*
Parbezol(RW) *35*
Pariet(JC) *35*
PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR 236, 834, 1069
PARITAPREVIR + RITONAVIR + OMBITASVIR & DASABUVIR & RIBAVIRIN 236, 237, 834, 1069, 1070
Parlodel(SZ)
.GENITO URINARY SYSTEM AND SEX HORMONES *177*
.NERVOUS SYSTEM *612*
Parnate(GH) *641*
PAROXETINE 640
Paroxetine AN(EA) *640*

Paroxetine GH (GQ) *640*
Paroxetine Sandoz(SZ) *640*
Parzol 10(ZP) *35*
Parzol 20 (ZP) *35*
PASIREOTIDE 828, 1063
Paxam 0.5(AF) *599*, *759*
Paxam 2(AF) *599*, *759*
Paxtine (AF) *640*
PAZOPANIB 277, 278, 279
Peg 7420(MM) *1581*
Peg 7422(MM) *1581*
Peg 7423(MM) *1581*
Peg 7425(MM) *1581*
Pegasys(RO) *306*, *848*, *1084*, *1251*
PEGFILGRASTIM 845, 1081
PEGINTERFERON ALFA-2A 306, 847, 848, 1084, 1251
PEGINTERFERON BETA-1A 306, 307
PEGVISOMANT 823, 1058, 1059
Pemzo (RW) *33*, *34*
PENICILLAMINE 565
Pentasa(FP) *50*, *51*, *52*
PENTASTARCH + SODIUM CHLORIDE 100
Penthrox(DV) *20*
Peptamen Junior(NT) *727*
PERAMPANEL 606
Pergoveris(SG) *1539*
PERHEXILINE 104
PERICIAZINE 616
Perindo (AF) *116*, *117*
Perindo Combi 4/1.25(AF) *120*
PERINDOPRIL 116, 117
PERINDOPRIL + AMLODIPINE 120
PERINDOPRIL + INDAPAMIDE 119
Perindopril Actavis 2(EA) *116*
Perindopril Actavis 4(ED) *117*
Perindopril Actavis 8(ED) *117*
Perindopril AN (EF) *116*, *117*
Perindopril and Indapamide AN 4/1.25(EF) *120*
Perindopril Combi Actavis 4/1.25 (ED) *120*
Perindopril generichealth(GQ) *117*
Perindopril/ Indapamide GH 4/1.25(GQ) *120*
PERMETHRIN 664
Persantin SR(BY) *88*
Petrus Bisacodyl Suppositories(PP) *44*, *749*, *750*, *1555*
Petrus Pharmaceuticals Pty Ltd(PP) *1556*
Pexsig(QA) *104*
Pfizer Australia Pty Ltd(PF)
.Prescriber Bag *18*, *20*
Pfizer Australia Pty Ltd(PF)
.ALIMENTARY TRACT AND METABOLISM *36*
Pfizer Australia Pty Ltd(PF)
.ALIMENTARY TRACT AND METABOLISM *36*
Pfizer Australia Pty Ltd(PF)
.BLOOD AND BLOOD FORMING ORGANS *84*
Pfizer Australia Pty Ltd(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *217*
Pfizer Australia Pty Ltd(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *217*
Pharmacor Amisulpride (CR) *624*
Pharmacor Amisulpride(CR) *624*
Pharmacor Amlodipine(CR) *113*
Pharmacor Atorvastatin(CR) *131*, *132*
Pharmacor Cefuroxime(CR) *210*, *211*
Pharmacor Citalo 20(CR) *637*
Pharmacor Diclofenac 50(CR) *558*, *559*, *751*
Pharmacor Donepezil 10(CR) *650*, *651*
Pharmacor Duloxetine 30(CR) *642*
Pharmacor Duloxetine 60(CR) *642*
Pharmacor Escitalopram 10 (CR) *637*
Pharmacor Escitalopram 20 (CR) *638*
Pharmacor Esomeprazole (CR) *31*, *32*
Pharmacor Finasteride 5(CR) *1569*
Pharmacor Gabapentin 600 (CR)
.NERVOUS SYSTEM *602*
Pharmacor Gabapentin 800 (CR)
.NERVOUS SYSTEM *603*
Pharmacor Letrozole 2.5(CR) *303*
Pharmacor Meloxicam 15(CR) *560*
Pharmacor Meloxicam 7.5(CR) *560*
Pharmacor Metformin 1000 (CR) *56*
Pharmacor Mycophenolate 250 (CR) *317*, *864*, *1100*
Pharmacor Mycophenolate 500 (CR) *316*, *863*, *1099*
Pharmacor Olmesartan 20 (CR) *124*
Pharmacor Olmesartan 40 (CR) *123*
Pharmacor Omeprazole 20(CR) *33*, *34*
Pharmacor Omeprazole(CR) *33*
Pharmacor Quetiapine 100(CR) *623*
Pharmacor Quetiapine 200(CR) *623*
Pharmacor Quetiapine 25(CR) *624*
Pharmacor Quetiapine 300(CR) *623*
Pharmacor Riluzole (CR) *661*
Pharmacor Rosuvastatin 10(CR) *134*, *135*, *136*, *137*
Pharmacor Rosuvastatin 20(CR) *134*, *135*, *136*, *137*
Pharmacor Rosuvastatin 40(CR) *134*, *135*, *136*, *137*
Pharmacor Rosuvastatin 5(CR) *134*, *135*, *136*, *137*
Pharmacor Sumatriptan 50 (CR) *597*
Pharmacor Tacrolimus 0.5 (CR) *555*, *957*, *1193*
Pharmacor Tacrolimus 1 (CR) *556*, *957*, *1193*
Pharmacor Tacrolimus 5 (CR) *555*, *956*, *1193*
Pharmacor Telmisartan 40(CR) *124*
Pharmacor Telmisartan 80(CR) *124*
Pharmacy Action Anti-Fungal Cream(GQ) *1560*
Pharmacy Action Anti-Fungal Nail Treatment(GQ) *1561*
Pharmacy Action Cetrelief(GQ) *1578*
Pharmacy Action Diarrhoea Relief(GQ) *1556*
Pharmacy Action FemCream (GQ) *1567*
Pharmacy Action Fexorelief 120(GQ) *1578*
Pharmacy Action Laxative with Senna(GQ) *1555*
Pharmacy Action Lorastyne(GQ) *1578*
Pharmacy Action Low Dose Aspirin (GQ) *1559*
Pharmacy Action Nystatin Oral Drops(GQ) *1554*
Pharmacy Action Pharmisil (GQ) *1561*
Pharmacy Action Sinus & Nasal Decongestant Relief(GQ)
.....*1577*
Pharmacy Action Worm Treatment(GQ) *1576*
Pharmacy Choice Finasteride (RI) *1569*
Phebra Naproxen Suspension(PL) *562*, *752*
PHENELZINE 641
Phenobarb(RW) *598*
PHENOBARBITAL (PHENOBARBITONE) 597
PHENOXYBENZAMINE
.CARDIOVASCULAR SYSTEM 109
.GENITO URINARY SYSTEM AND SEX HORMONES
.....188
PHENOXYMETHYLPENICILLIN 203, 204
Phenoxymethylpenicillin-AFT(AE) *203*, *204*
Phenylalanine 50(VF) *745*
PHENYLALANINE WITH CARBOHYDRATE 744
PHENYTOIN 598
Phlexy-10 Drink Mix(SB) *740*
Phlexy-10(SB) *740*
Phlexy-Vits(SB) *746*
PHOLCODINE 1578
Phosphate Sandoz(PL) *710*
PHOSPHORUS 710
Physeptone(QA) *588*
Physiotens(GO) *105*
PHYTOMENADIONE 21
Piax (AF) *1559*
Piax Plus Aspirin(AF) *88*

Piax(AF) *87*
Picato(LO) *1564*
PILOCARPINE 683
PIMECROLIMUS 175
PINDOLOL 109
Pinetarsol(EO) *1563*
PIOGLITAZONE 67
Pioglitazone AN (EA) *69*
Pioglitazone Sandoz(SZ) *69*
PIRFENIDONE 556
PIROXICAM 560
Pizaccord (RA) *69*
PIZOTIFEN 597
PKU Air 15(VF) *736*
PKU Air 20(VF) *736*
PKU Anamix First Spoon(SB) *739*
PKU Anamix infant(SB) *740*
PKU Anamix Junior LQ(SB) *737*
PKU Anamix Junior(SB) *737*
PKU Baby(OH) *733*
PKU Bettermilk Lite(QH) *743*
PKU Cooler 10(VF) *736*
PKU Cooler 15(VF) *736*
PKU Cooler 20(VF) *737*
PKU Easy Microtabs(OH) *733*
PKU Easy Shake & Go(OH) *733*
PKU Easy(OH) *745*
PKU express 15(VF) *737*
PKU express 20(VF) *736*
PKU gel(VF) *736*
PKU Glytactin RTD 10(QH) *742*
PKU Glytactin RTD 15(QH) *742*
PKU Go(OH) *733*
PKU Lophlex LQ 10(SB) *736*
PKU Lophlex LQ 20(SB) *737*
PKU Lophlex Sensation 20(SB) *737*
PKU Lophlex(SB) *737*
PKU Restore(QH) *743*
PKU Sphere15(VF) *743*
PKU Sphere20(VF) *743*
PKU squeezie(VF) *737*
Placil (AF) *636*
Plaqacide(OB) *1554*
Plaquenil (SW) *564*
Plavicor 75 (CR) *87*
Plavix (SW) *87*
Plavix(SW) *87*, *1559*
Plegridy(BD) *307*
Plendil ER(GX) *113*
PLERIXAFOR 848, 1084
Plidogrel (RF) *88*, *1559*
Plidogrel(RF) *86*
PNEUMOCOCCAL PURIFIED CAPSULAR POLYSACCHARIDES 238
Pneumovax 23(CS) *238*
PODOPHYLLOTOXIN 1563
Poly Gel(NV) *698*
Poly Visc(NV) *703*, *704*
POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL 704, 705
POLYLACTIC ACID 711
Polytar(GK) *1565*
Poly-Tears(NM) *701*
POLYVINYL ALCOHOL 705
POMALIDOMIDE 961, 1197
Pomalyst(CJ) *962*, *1198*
PONATINIB 280, 282
Ponstan(PF) *563*
POSACONAZOLE 225, 226
POTASSIUM CHLORIDE 80
POTASSIUM CHLORIDE + POTASSIUM BICARBONATE + POTASSIUM CARBONATE 80
POVIDONE-IODINE
.Repatriation Pharmaceutical Benefits Scheme 1564, 1597
Pradaxa(BY) *91*, *92*
Pramin(AF) *36*
PRAMIPEXOLE 612, 613
Pramipexole AN (EA) *612*, *613*
Pramipexole XR GP (AF) *613*
PRASUGREL 89
Pravachol(RW) *133*, *134*
PRAVASTATIN 132, 133
Pravastatin AN(EA) *133*, *134*
Pravastatin generichealth (GQ) *133*, *134*
Pravastatin Sandoz(SZ) *133*, *134*
PRAZIQUANTEL 663
PRAZOSIN 106
PredMix(LN) *194*
Prednefrin Forte(AG) *682*
PREDNISOLONE 194
PREDNISOLONE ACETATE + PHENYLEPHRINE 681, 682
PREDNISOLONE SODIUM PHOSPHATE
.ALIMENTARY TRACT AND METABOLISM 49
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 194
PREDNISONE 195
Predsol(QA) *49*
Predsolone(LN) *194*
Predsone(LN) *195*
PREGABALIN 594
Pregabalin AMNEAL(EA) *594*
Pregabalin APOTEX (GX) *594*
Pregabalin GH (GQ) *594*
Pregabalin Sandoz(SZ) *594*
PREGABALIN-DRLA(RZ) *594*
Pregabalin-Teva (TB) *594*
Pregnyl(MK) *186*, *1539*
Prenoxad(PL) *708*
PREPARED COAL TAR 163
Presolol 100(AF) *112*
Presolol 200(AF) *112*
PREXUM 10 (RW) *117*
PREXUM 2.5 (RW) *116*
PREXUM 5 (RW) *117*
Prexum Combi 5/1.25(RW) *120*
PREXUM Combi LD 2.5/0.625(RW) *119*
Prezcobix(JC) *1244*
Prezista(JC) *1234*
PRIMIDONE 598
Primolut N(BN) *183*
Prioten 15(DO) *69*
Prioten 30 (DO) *69*
Prioten 45(DO) *69*
Pristiq(PF) *642*
Pritor Plus 40/12.5 mg(FI) *127*
Pritor Plus 80/12.5 mg(FI) *127*
Pritor Plus 80/25 mg(FI) *127*
Pritor/Amlodipine(FI) *129*
Pro-Banthine(RW) *188*
PROBENECID 566
Probitor (SZ) *33*, *34*
PROCAINE BENZYLPENICILLIN (PROCAINE PENICILLIN) 18, 204
ProCalm (RW) *42*
PROCHLORPERAZINE 20, 42
Prochlorperazine AN(EA) *42*
Prochlorperazine GH (GQ) *42*
Pro-Cid(PL) *566*
Prodeine Forte (AV) *589*

Profore 66050016(SN) *1580*
Profore Lite 66050415(SN) *1580*
PROGESTERONE 1537
Progout 100 (AF) *566*
Progout 100(AF) *566*
Progout 300 (AF) *566*
Prograf XL (LL) *555*, *956*, *957*, *1193*
Prograf(LL) *555*, *556*, *956*, *957*, *1193*
Progynova(BN) *182*
Proladone(PL) *583*
Prolia(AN) *575*
PROMETHAZINE
.ALIMENTARY TRACT AND METABOLISM 43
.Prescriber Bag 21
.RESPIRATORY SYSTEM 677
Prontosan Wound Irrigation Solution(BR) *1584*
PROPANTHELINE 188
PROPRANOLOL 109
PROPYLTHIOURACIL 196
Proscar (MK) *1569*
Protaphane (NO) *55*
Protaphane InnoLet (NI) *55*
Protaphane Penfill 3 mL(NO) *55*
PROTEIN FORMULA WITH AMINO ACIDS, CARBOHYDRATES, VITAMINS AND MINERALS WITHOUT PHENYLALANINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID 745
PROTEIN FORMULA WITH ARGININE, VITAMIN C AND E 1579
PROTEIN FORMULA WITH ARGININE, VITAMIN C, E AND ZINC 1579
PROTEIN FORMULA WITH CARBOHYDRATE, FAT, VITAMINS AND MINERALS 712
PROTEIN HYDROLYSATE FORMULA WITH MEDIUM CHAIN TRIGLYCERIDES 723, 725
Provera(PF)
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS *296*
.GENITO URINARY SYSTEM AND SEX HORMONES *183*
Proxen SR 1000(IY) *562*, *563*, *752*
Proxen SR 750(IY) *562*, *563*, *752*
Prozac 20(LY) *639*
Prozac Tab(LY) *639*
ProZero(VF) *745*
PRYZEX ODT(RW) *620*, *621*
PRYZEX(RW) *619*, *620*
PSEUDOEPHEDRINE 1577
PSYLLIUM HUSK POWDER 1555
PTU(PL) *196*
Pulmicort Respules(AP) *672*
Pulmicort Turbuhaler(AP) *671*, *672*
Pulmozyme(RO) *988*, *1224*
Puregon 300 IU/0.36 mL(MK) *185*, *1539*
Puregon 600 IU/0.72 mL(MK) *185*, *1539*
Puregon 900 IU/1.08 mL(MK) *185*, *1539*
Purinethol(AS) *241*
PVA Tears(PE) *705*
Pyralin EN(FZ) *52*
PYRANTEL 664
PYRIDOSTIGMINE 656
PYRIMETHAMINE 662
Qpril 10(AF) *117*
Qpril 20 (AF) *117*
Qpril 5(AF) *117*
QUEPINE XR (RF) *622*, *623*
QUEPINE XR(RW) *623*
Questran Lite(QA) *140*
Quetia 100 (RW) *623*
Quetia 200 (RW) *623*
Quetia 25 (RW) *624*
Quetia 300 (RW) *623*
QUETIAPINE 622, 623
Quetiapine Actavis 100(ED) *623*
Quetiapine Actavis 200(ED) *623*
Quetiapine Actavis 300(ED) *623*
Quetiapine AN (EA) *623*
Quetiapine AN(EA) *624*
Quetiapine GH 100 (GQ) *623*
Quetiapine GH 200 (GQ) *623*
Quetiapine GH 25(GQ) *624*
Quetiapine GH 300 (GQ) *623*
Quetiapine RBX (RA) *624*
Quetiapine RBX(RA) *623*
Quetiapine Sandoz (SZ) *623*
Quetiapine Sandoz(SZ) *624*
QUETIAPINE-AS XR(RW) *622*, *623*
Quetiapine-DRLA (RZ) *624*
Quetiapine-DRLA(RZ) *623*
Quilonum SR(AS) *642*
QUINAGOLIDE 178
QUINAPRIL 117
QUINAPRIL + HYDROCHLOROTHIAZIDE 120
Quinapril generichealth(GQ) *117*
Quinate(RW) *662*
QUININE 662
QuitX(AF) *1576*
QV Bath Oil(EO) *1562*
Qvar 100 Autohaler(IA) *671*
Qvar 100(IA) *671*
Qvar 50 Autohaler(IA) *671*
Qvar 50(IA) *671*
RABEPRAZOLE 34, 35
Rabeprazole AN (EA) *35*
Rabeprazole AN(EA) *35*
Rabeprazole generichealth (GQ) *35*
Rabeprazole generichealth(GQ) *35*
Rabeprazole Sandoz (SZ) *35*
Rabeprazole Sandoz(SZ) *35*
Rabeprazole SUN(RN) *35*
Rabeprazole-DRLA (RZ) *35*
Rabeprazole-DRLA(RZ) *35*
Ralovera(FZ) *183*
RALOXIFENE 575
Raloxifene AMNEAL(ED) *575*
Raloxifene AN (EA) *575*
RALTEGRAVIR 1249
Ramace 1.25 mg(AV) *118*
Ramace 10 mg(AV) *117*
Ramace 2.5 mg(AV) *118*
Ramace 5 mg(AV) *118*
RAMIPRIL 117, 118
RAMIPRIL + FELODIPINE 121
Ramipril AN (EA) *117*, *118*
Ramipril AN(EA) *118*
Ramipril generichealth(GQ) *117*, *118*
Ramipril Sandoz (SZ) *117*, *118*
Ramipril Sandoz(SZ) *118*
Ramipril Winthrop (WA) *118*
Ramipril Winthrop(WA) *117*, *118*
Rancef (RA) *208*
Rancef(RA) *207*, *208*
Rani 2 (AF) *30*
RANIBIZUMAB 692, 693, 695
RANITIDINE 30
Ranitidine AN(EA) *30*
Ranitidine GH (GQ) *30*
Ranitidine GH(GQ) *30*
Ranitidine Sandoz (SZ) *30*
Ranitidine Sandoz(SZ) *30*

Ranmoxy (RA) *201*
Ranmoxy(RA) *202*
Ransim (RA) *137*, *138*, *139*
Ranzepam(RA) *632*, *759*
Rapamune(PF) *317*, *865*, *866*, *1102*
Rapilysin 10 U(GN) *90*
RASAGILINE 614
Razit 10 (DO) *35*
Razit 20 (DO) *35*
RBX Topiramate(RA) *607*, *608*
RCF(AB) *745*
Reandron 1000(BN) *181*
Reaptan 10/10 (RW) *121*
Reaptan 10/5 (RW) *121*
Reaptan 5/10 (RW) *121*
Reaptan 5/5 (RW) *121*
Rebif 44(SG) *305*, *306*
REBOXETINE 643
ReddyMax Plus D-Cal (RZ) *572*
Redipred(AS) *194*
Reedos 100(DO) *605*
Reedos 200(DO) *605*
Reedos 25 (DO) *605*
Reedos 50 (DO) *605*
Refresh Liquigel(AG) *699*, *700*
Refresh Night Time(AG) *703*, *704*
Refresh Tears Plus(AG) *699*, *700*
Relistor(LM) *751*
Relpax(PF) *595*
Remeron SolTab (AF) *643*
Remicade (JC) *889*, *893*, *897*, *902*, *907*, *912*, *916*, *920*, *928*, *1125*, *1129*, *1133*, *1138*, *1143*, *1147*, *1152*, *1157*, *1164*
Remicade(JC) *1571*
Reminyl(JC) *651*, *652*, *653*
Renagel(GZ) *709*, *994*, *1231*
Renastart(VF) *747*
RenaStart(VF) *747*
Renflexis(MK) *889*, *893*, *897*, *902*, *907*, *912*, *916*, *920*, *928*, *1125*, *1129*, *1133*, *1138*, *1143*, *1147*, *1152*, *1157*, *1164*
Renitec 20(MK) *115*
Renitec Plus 20/6(MK) *119*
Renitec(MK) *115*
ReoPro(JC) *86*
Repalyte New Formulation (SW) *48*
Repalyte New Formulation(SW) *48*
Repatha(AN) *141*
Replicare Ultra 66000434(SN) *1592*
Resolve Thrush(EO) *1561*
Resonium-A(SW) *1579*
Respikast 4 (RW) *676*
Respikast 5 (RW) *676*
Resprim Forte(AF) *213*, *214*
restore O.R.S. (EA) *48*
restore O.R.S.(EA) *48*, *1556*
RETEPLASE 90
Retrovir(VI) *1241*
Revatio (PF) *818*, *1053*
ReVia(BQ) *660*
Revlimid(CJ) *958*, *959*, *961*, *1194*, *1196*, *1197*
Revolade(NV) *765*, *1000*
Rexulti(LU) *625*, *626*
Reyataz(BQ) *1233*
RHAMNUS FRANGULA + STERCULIA 44, 750, 1556
Riamet 20mg/120mg Dispersible(SZ) *663*
Riamet(SZ) *663*
RIBAVIRIN 232, 830, 831, 1066
Ridaura(BZ) *564*
Ridaura(GH) *564*
RIFABUTIN 830, 1065
Rifadin(SW) *229*
RIFAMPICIN 229
RIFAXIMIN 47
RILPIVIRINE 1243
Rilutek(SW) *661*
RILUZOLE 661
Riluzole Sandoz (SZ) *661*
Rimycin 150(AF) *229*
Rimycin 300(AF) *229*
RIOCIGUAT 802, 805, 1037, 1040
Risedro once a week (RW) *1571*
Risedro once a week(RW) *569*
RISEDRONATE 568, 1571
RISEDRONATE (&) CALCIUM CARBONATE 572, 1572
RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL 573, 1572
Risedronate AN(EA) *569*, *1571*
Risedronate Sandoz (SZ) *569*
Risedronate Sandoz(SZ) *1571*
Risedronate-GA (GN) *1571*
Rispa (RW) *629*, *631*
Rispa(RW) *627*, *628*, *630*
Risperdal (JC) *627*, *628*, *629*, *630*, *631*
Risperdal Consta(JC) *628*, *629*
Risperdal(JC) *627*, *630*
Rispericor 0.5(CR) *629*, *631*
Rispericor 1(CR) *627*, *630*
Rispericor 2(CR) *627*, *628*
RISPERIDONE 627, 628, 629, 630
Risperidone AMNEAL (EF) *627*, *628*, *629*, *630*, *631*
Risperidone AMNEAL(EF) *627*
Risperidone generichealth (GQ) *627*
Risperidone generichealth(GQ) *627*, *628*, *630*
Risperidone Sandoz (SZ) *627*, *628*, *630*
Risperidone Sandoz(SZ) *627*, *629*, *631*
Rispernia (ER) *627*, *629*, *631*
Rispernia(ER) *627*, *628*, *630*
Ristempa (GV) *846*, *1082*
Ritalin 10 (NV) *648*
Ritalin LA(NV) *648*
Rithmik 200 (RW) *102*
RITONAVIR 1235
RITUXIMAB
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 242, 243
.Highly Specialised Drugs Program (Private Hospital) 838, 962
.Highly Specialised Drugs Program (Public Hospital) 1073, 1198
RIVAROXABAN 94, 95, 96
Rivastigmelon Patch 10 (AF) *653*, *654*
Rivastigmelon Patch 5 (AF) *653*, *654*
RIVASTIGMINE 653
Rivotril(RO) *18*, *599*, *759*
Rixadone (AF) *627*, *628*, *630*
Rixadone(AF) *627*, *629*, *631*
RIZATRIPTAN 596
Rizatriptan AN ODT (EA) *596*
Rizatriptan ODT GH(GQ) *596*
Rizatriptan Wafers-10mg (AF) *596*
Roaccutane (RO) *175*
Rocaltrol(RO)
.ALIMENTARY TRACT AND METABOLISM *79*
.MUSCULO-SKELETAL SYSTEM *574*
Rocta 10(RW) *174*
Rocta 20(RW) *175*
Roferon-A(RO) *304*, *847*, *1083*, *1250*
ROMIPLOSTIM 765, 1000
ROSIGLITAZONE + METFORMIN 63
Rostor 10 (DO) *135*, *137*
Rostor 20 (DO) *135*, *137*

Rostor 40 (DO) *135*, *137*
Rostor 5 (DO) *135*, *137*
ROSUVASTATIN 134, 135, 136
ROSUVASTATIN (&) EZETIMIBE 154, 157
Rosuvastatin AMNEAL (EF) *134*, *136*
Rosuvastatin AMNEAL(EF) *135*, *137*
Rosuvastatin generichealth (HQ) *134*, *135*, *136*
Rosuvastatin generichealth(HQ) *135*, *137*
Rosuvastatin GH (GQ) *135*, *137*
Rosuvastatin GH(GQ) *134*, *135*, *136*
Rosuvastatin RBX(RA) *135*, *137*
Rosuvastatin Sandoz (SZ) *135*, *137*
Rosuvastatin-DRLA (RI) *135*, *137*
Rosuvastatin-DRLA(RI) *134*, *135*, *136*
Rosuzet Composite Pack(MK) *156*, *157*, *159*
ROTIGOTINE 614
Roxar 150 (RW) *216*
Roxar 300 (RW) *216*
Roxet 20(DO) *640*
Roximycin(AF) *216*
Roxin(RW) *220*
ROXITHROMYCIN 216
Roxithromycin AN (EA) *216*
Roxithromycin GH (GQ) *216*
Roxithromycin Sandoz(SZ) *216*
Roxithromycin-GA(ED) *216*
Rulide D(SW) *216*
Rulide(SW) *216*
RUXOLITINIB 283, 284
Rynacrom(SW) *1577*
Rythmodan(SW) *101*
S-26 Original LI(AS) *733*
Sabril(SW) *602*
SACUBITRIL + VALSARTAN 130
Saflutan(MF) *688*
Saizen(SG) *1285*, *1396*, *1490*
Salazopyrin(PF) *52*
Salazopyrin-EN(PF) *52*
SALBUTAMOL
.Prescriber Bag 22
.RESPIRATORY SYSTEM 665, 666, 675
Salbutamol Actavis(EA) *22*, *666*
Salbutamol AN (ED) *22*, *666*
Salbutamol Sandoz(SZ) *22*, *666*
SALICYLIC ACID + BENZALKONIUM CHLORIDE + ALCOHOL + COAL TAR SOLUTION + POLYOXYETHYLENE ETHERS 1565
SALICYLIC ACID + LACTIC ACID 1565
SALMETEROL 666
Salofalk(OA) *50*, *51*
SalplusF Inhaler 125/25 (YC) *669*
SalplusF Inhaler 250/25 (YC) *669*
Salpraz (AF) *34*
Sandimmun(NV) *955*, *1191*
Sandomigran 0.5(AE) *597*
Sandostatin 0.05 (NV) *827*, *1063*
Sandostatin 0.1 (NV) *828*, *1063*
Sandostatin 0.5 (NV) *828*, *1063*
Sandostatin LAR(NV) *827*, *1062*
Sandoz Lamotrigine(HX) *605*
Sandoz Nail Repair(SZ) *1561*
Sandoz Venlafaxine XR(HX) *644*
Sandrena(AS) *182*
Saphris(LU) *618*
SAPROPTERIN 81, 82
SAQUINAVIR 1235
Savacol Mouth and Throat Rinse(OM) *1554*
SAXAGLIPTIN 71
SAXAGLIPTIN + METFORMIN 64
Sculptra(GA) *711*
Scytera(RZ) *163*
SebiRinse(EO) *1566*
Sebitar(EO) *1565*
Sebizole(EA) *1561*
SECUKINUMAB 503, 505, 506, 508, 510, 513, 516, 520, 523
seebri breezhaler(NV) *673*
SELEGILINE 614
SELENIUM SULFIDE 1565
Selsun(DQ) *1565*
Senna-Gen(PP) *1555*
SENNOSIDE B 1555
Senokot(RC) *1555*
Septrin Forte(RW) *213*, *214*
Septrin(RW) *213*
Serenace(QA) *18*, *616*
Serepax(QA) *633*, *759*
Seretide Accuhaler 100/50(GK) *669*
Seretide Accuhaler 250/50(GK) *669*
Seretide Accuhaler 500/50(GK) *669*
Seretide MDI 125/25(GK) *669*
Seretide MDI 250/25(GK) *669*
Seretide MDI 50/25(GK) *669*
Serevent Accuhaler(GK) *666*
Seroquel (AP) *624*
Seroquel XR (AP) *622*, *623*
Seroquel(AP) *623*
Sertra 100(RW) *640*
Sertra 50(RW) *640*
Sertracor 100 (CR) *640*
Sertracor 50 (CR) *640*
SERTRALINE 640
Sertraline AN(EA) *640*, *641*
Sertraline generichealth (GQ) *640*
Sertraline Sandoz(SZ) *640*
Setopress 3505(MH) *1580*
Setrona (RA) *640*
SEVELAMER 709, 994, 1231
Sevikar 20/5(MK) *128*
Sevikar 40/10(MK) *129*
Sevikar 40/5(MK) *129*
Sevikar HCT 20/5/12.5(MK) *130*
Sevikar HCT 40/10/12.5(MK) *130*
Sevikar HCT 40/10/25(MK) *130*
Sevikar HCT 40/5/12.5(MK) *130*
Sevikar HCT 40/5/25(MK) *130*
Sevredol(MF) *579*, *753*
Shilova 500(DO) *233*
Sical(AF)
.ALIMENTARY TRACT AND METABOLISM *79*
.MUSCULO-SKELETAL SYSTEM *574*
Sifrol ER(BY) *613*
Sifrol(BY) *612*, *613*, *614*
Sigmacort(QA) *164*, *165*
Sigmaxin(FM) *101*
Sigmaxin-PG(FM) *101*
Signifor LAR(NV) *829*, *1064*
Silaran(RA) *1568*
SILDENAFIL
.Highly Specialised Drugs Program (Private Hospital) 813
.Highly Specialised Drugs Program (Public Hospital) 1048
.Repatriation Pharmaceutical Benefits Scheme 1567
Sildenafil Actavis (EA) *1567*
Sildenafil Actavis(EA) *1567*, *1568*
Sildenafil AN PHT 20(EA) *818*, *1053*
Sildenafil generichealth (GQ) *1568*
Sildenafil Sandoz PHT 20(SZ) *818*, *1053*
SILDENAFIL-DRx (RZ) *818*, *1053*
Silic 15(EO) *1562*
SILVER SULFADIAZINE 164

Simbrinza 1%/0.2%(NV) *684*
Simipex 0.125 (RW) *612*
Simipex 0.25 (RW) *612*
Simipex 1 (RW) *613*
SIMIPEX XR (RW) *613*
Simplotan(FZ) *222*
Simponi(JC) *477*, *481*, *483*, *485*, *488*, *491*, *492*
Simpral(AF) *612*, *613*
Simvacor 10(CR) *138*, *139*
Simvacor 20(CR) *138*, *139*
Simvacor 40(CR) *138*, *139*
Simvacor 80(CR) *137*, *138*
Simvar 10 (RW) *138*, *139*
Simvar 20 (RW) *138*, *139*
Simvar 40 (RW) *138*, *139*
Simvar 80 (RW) *137*, *138*
SIMVASTATIN 137, 138
Simvastatin AN(EA) *138*, *139*
Simvastatin generichealth (GQ) *138*, *139*
Simvastatin Sandoz(SZ) *138*, *139*
Sinemet 100/25(MK) *610*
Sinemet CR(MK) *610*
Sinemet(MK) *610*
Sinequan(PF) *636*
Singulair(MK) *676*
Sintetica Baclofen Intrathecal(BZ) *967*, *968*, *1203*, *1204*
SIROLIMUS 317, 865, 1101
SITAGLIPTIN 72
SITAGLIPTIN + METFORMIN 65
SKIN EMOLLIENT 1562
Slow-K(NV) *80*
Sno-Pro(SB) *745*
Sodibic(AS) *188*
SODIUM AUROTHIOMALATE 565
SODIUM CHLORIDE 1560
SODIUM CHLORIDE + HYPOCHLOROUS ACID + SODIUM HYPOCHLORITE 1597
SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE MONOHYDRATE + CITRIC ACID ... 48, 1556
SODIUM HYALURONATE 706
SODIUM POLYSTYRENE SULFONATE 1579
Sodium Valproate Sandoz(SZ) *601*
Soflax(EA) *1555*
SOFOSBUVIR 237, 835, 1070
SOFOSBUVIR + VELPATASVIR 237, 835, 1070
Sofradex(SW) *707*
Soframycin(SW) *707*
Solaraze 3% Gel(FK) *1565*
Solavert(RF) *102*
Solian 100 (SW) *624*
Solian 200 (SW) *624*
Solian 400(SW) *624*
Solian Solution(SW) *624*
Soliris(XI) *856*, *857*, *858*, *862*, *1092*, *1093*, *1095*, *1099*
Solone (IA) *194*
SoloSite Gel 36361338(SN) *1595*
Solprin(RC)
.BLOOD AND BLOOD FORMING ORGANS *86*
.NERVOUS SYSTEM *592*
Solu-Cortef(PF) *19*, *193*, *194*
Solugel 10336(JJ) *1594*
Solu-Medrol(PF) *194*
Somac(NQ) *34*
SOMATROPIN .1262, 1270, 1277, 1285, 1294, 1302, 1311, 1327, 1344, 1361, 1379, 1396, 1414, 1433, 1452, 1471, 1490, 1512
Somatuline Autogel(IS) *826*, *1061*
Somatuline LA(IS) *826*, *1061*
Somavert(PF) *823*, *825*, *1059*, *1060*
Sone (IA) *195*
SORAFENIB 285
Sorbact Absorption Dressing S98222(QL) *1594*
Sorbact Foam Dressing S98310(QL) *1595*
Sorbact Ribbon Gauze S98118(QL) *1595*
Sorbact Ribbon Gauze S98120(QL) *1595*
SORBITOL + CITRIC ACID + LAURYL SULFOACETATE SODIUM 46, 751, 1556
Sorbsan 1410(UM) *1585*
Sorbsan 1411(UM) *1585*
Sotacor(RW) *102*
SOTALOL 102
Sotalol Sandoz (SZ) *102*
Sovaldi(GI) *237*, *835*, *1070*
SOY LECITHIN + TOCOPHEROL + VITAMIN A 706
SOY PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE 745
Sozol (RW) *34*
Span-K(AS) *80*
Spiolto Respimat(BY) *671*
Spiractin 100(AF) *108*
Spiractin 25(AF) *108*
Spiriva Respimat(BY) *673*, *674*
Spiriva(BY) *673*
SPIRONOLACTONE 108
Sporanox (JC) *225*
Spren 100(OW) *86*, *1558*
Sprycel(BQ) *252*, *254*, *255*
Stalevo 100/25/200mg(NV) *611*
Stalevo 125/31.25/200mg(NV) *611*
Stalevo 150/37.5/200mg(NV) *611*
Stalevo 200/50/200mg(NV) *611*
Stalevo 50/12.5/200mg(NV) *611*
Stalevo 75/18.75/200mg(NV) *611*
Staphylex 250(AF) *205*
Staphylex 500(AF) *205*, *206*
STAVUDINE 1239
Stelara(JC) *537*, *540*, *543*, *549*, *555*, *955*, *1191*
Stelax 10(RW) *565*
Stelax 25(RW) *565*
Stelazine(GH) *615*, *616*
Stemetil(SW) *20*, *42*, *43*
Stemzine(AV) *42*, *43*
Steripaste 3610(MH) *1583*
Stocrin(MK) *1241*, *1242*
Strattera(LY) *646*
Stribild(GI) *1247*
Stromectol(MK) *664*
Suboxone Film 2/0.5(IR) *1543*
Suboxone Film 8/2(IR) *1543*
Subutex(IR) *1543*
SUCCINYLATED GELATIN 100
SUCRALFATE 35
SUCROFERRIC OXYHYDROXIDE 709, 994, 1231
SULFASALAZINE 52
Sulprix (AF) *624*
Sulprix(AF) *624*
SULTHIAME 607
Sumatran (OW) *596*
Sumatran(OW) *597*
SUMATRIPTAN 596
Sumatriptan AN (EA) *597*
Sumatriptan generichealth(GQ) *597*
Sumatriptan RBX (RA) *597*
Sumatriptan Sandoz(SZ) *596*, *597*
SUNITINIB 286, 287, 288
SUNSCREENS 1562
Sunsense Sensitive SPF 50+(EO) *1562*
Sunsense Ultra SPF 50+(EO) *1562*
Surepress 650947(CC) *1580*
Surepress 650948(CC) *1580*

Sutent(PF) *286*, *287*, *288*, *289*
Symbicort Rapihaler 100/3(AP) *667*
Symbicort Rapihaler 200/6(AP) *668*
Symbicort Rapihaler 50/3(AP) *667*
Symbicort Turbuhaler 100/6(AP) *667*
Symbicort Turbuhaler 200/6(AP) *667*
Symbicort Turbuhaler 400/12(AP) *668*
Symmetrel 100(NV) *611*
Synacthen Depot 1 mg/1 mL(LM) *189*
Synarel(PF) *191*, *1540*
Syquet (AF) *623*
Syquet(AF) *624*
Systane(NV) *704*, *705*
Tacidine (AF) *30*
TACROLIMUS 555, 956, 1192
TACROLIMUS APOTEX (TX) *555*, *556*, *956*, *957*, *1193*
Tacrolimus Sandoz(SZ) *555*, *556*, *956*, *957*, *1193*
TADALAFIL
.Highly Specialised Drugs Program (Private Hospital) 818
.Highly Specialised Drugs Program (Public Hospital) 1053
.Repatriation Pharmaceutical Benefits Scheme 1568
Tafinlar(NV) *250*
TAFLUPROST 688
Talam (RW) *637*
Talam(RW) *637*
Taltz(LY) *497*, *503*
Tamate (AF) *607*, *608*
Tambocor (IA) *101*
Tambocor(IA) *101*
Tamosin(QA) *299*
TAMOXIFEN 299
Tamoxifen Sandoz (SZ) *299*
Tamsil (RW) *162*, *163*
Tamsil(RW) *1561*
TAMSULOSIN 1569
Tamsulosin Sandoz SR (SZ) *1569*
TAPE NON WOVEN RETENTION POLYACRYLATE . 1597
TAPE PLASTER ADHESIVE ELASTIC 1597
TAPE PLASTER ADHESIVE HYPOALLERGENIC 1597
TAPE PLASTER ADHESIVE WITH SILICONE 1598
TAPENTADOL 590
TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF COAL TAR 1565
TAR + TRIETHANOLAMINE LAURYL SULFATE 1563
Tarceva(RO) *255*, *256*
Targin 10/5mg(MF) *585*
Targin 15/7.5mg(MF) *585*
Targin 2.5/1.25 mg(MF) *585*
Targin 20/10mg(MF) *585*
Targin 30/15 mg(MF) *585*
Targin 40/20mg(MF) *585*
Targin 5/2.5mg(MF) *585*
Targin 60/30(MF) *585*
Targin 80/40(MF) *585*
Tarka 2/180(GO) *121*
Tarka 4/240(GO) *122*
Tasigna(NV) *274*, *276*
Tazac(RW) *30*
Tears Naturale(NV) *701*
tearsagain(RB) *706*
Tecfidera(BD) *660*, *661*
Tegaderm Transparent 1628(MM) *1586*
Tegaderm Transparent Island 3582(MM) *1586*
Tegaderm Transparent Island 3586(MM) *1586*
Tegretol 100(NV) *599*, *600*
Tegretol 200(NV) *600*
Tegretol CR 200(NV) *600*
Tegretol CR 400(NV) *600*
Tegretol Liquid(NV) *600*
Telfa 8252F(KE) *1581*
Telfa 8253F(KE) *1581*
Telfa 8254F(KE) *1581*
Telfast 120(SW) *1578*
Telfast(SW) *1578*
TELMISARTAN 124
TELMISARTAN + AMLODIPINE 129
TELMISARTAN + HYDROCHLOROTHIAZIDE 127
Telmisartan AN (EA) *124*
Telmisartan GH (GQ) *124*
Telmisartan HCT GH 40/12.5 (GQ) *127*
Telmisartan HCT GH 80/12.5 (GQ) *127*
Telmisartan HCT GH 80/25 (GQ) *127*
Telmisartan HCTZ AN 40/12.5 (EA) *127*
Telmisartan HCTZ AN 80/12.5 (EA) *127*
Telmisartan HCTZ AN 80/25 (EA) *127*
Telmisartan Sandoz(SZ) *124*
Telmisartan/HCT Sandoz(SZ) *127*
Telmisartan-DRLA(RZ) *124*
Teltartan (RW) *124*
Teltartan HCT 40/12.5(RW) *127*
Teltartan HCT 80/12.5(RW) *127*
Teltartan HCT 80/25(RW) *127*
Telzir(VI) *1235*
Temaze (AF) *634*, *635*, *760*
TEMAZEPAM 634, 760
Temizole 100(QA) *239*, *240*
Temizole 140(QA) *240*
Temizole 20(QA) *240*
Temizole 250(QA) *239*
Temizole 5(QA) *239*, *240*
Temodal (MK) *239*, *240*
Temodal(MK) *239*, *240*
Temolide (JU) *239*, *240*
Temolide(JU) *239*, *240*
TEMOZOLOMIDE 239, 240
Temozolomide Alphapharm (AF) *239*, *240*
Temozolomide Amneal(ED) *239*, *240*
Temtabs(FM) *634*, *635*, *760*
Tenaxil SR(RW) *107*
TenderWet 24 Active 609210(HR) *1590*
TenderWet 24 Active 609213(HR) *1590*
TenderWet Active Cavity 609272(HR) *1590*
TENECTEPLASE 90
TENOFOVIR 1240
TENOFOVIR + EMTRICITABINE 1246
TENOFOVIR + EMTRICITABINE + EFAVIRENZ 1247
TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT 1247
TENOFOVIR + EMTRICITABINE + RILPIVIRINE 1247
TENOFOVIR ALAFENAMIDE + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT 1247
Tenofovir Disoproxil Emtricitabine Mylan 300/200(AF) . *1247*
Tenofovir Disoproxil Mylan(AF) *1241*
Tenofovir EMT GH(GQ) *1247*
Tenofovir GH(GQ) *1241*
Tenolten 50 (DO) *110*
Tenormin(AP) *110*
Tensig(RW) *110*
Tensocrepe 36300501(BV) *1581*
Tensocrepe 36301001(BV) *1581*
Tensocrepe 36307501(BV) *1581*
Tensopress 71723-00(BV) *1580*
TERBINAFINE
.DERMATOLOGICALS 162
.Repatriation Pharmaceutical Benefits Scheme 1561
Terbinafine AN(EA) *162*, *163*
Terbinafine GH (GQ) *1561*
Terbinafine GH(GQ) *162*, *163*
Terbinafine Sandoz (SZ) *162*, *163*
Terbinafine Sandoz(SZ) *1561*

Terbinafine-DRLA (RZ) *162*, *163*
TERBUTALINE
.RESPIRATORY SYSTEM 666, 675
TERIFLUNOMIDE 317
TERIPARATIDE
.MUSCULO-SKELETAL SYSTEM 575
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 197
Terry White Chemists Alendronate Plus D3 70 mg/140 mcg(TW) *571*, *1572*
Terry White Chemists Alendronate Plus D3 70 mg/70 mcg (TW) *572*
Terry White Chemists Alendronate Plus D3 70 mg/70 mcg(TW) *1572*
Terry White Chemists Allopurinol(TW) *566*
Terry White Chemists Amitriptyline(TW) *635*
Terry White Chemists Amlodipine (TW) *113*
Terry White Chemists Amoxycillin and Clavulanic Acid(TW) *206*, *207*
Terry White Chemists Atenolol (TW) *110*
Terry White Chemists Atorvastatin (TW) *131*, *132*
Terry White Chemists Azithromycin (TW)
.Repatriation Pharmaceutical Benefits Scheme *1570*
Terry White Chemists Azithromycin(TW)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*
Terry White Chemists Bisoprolol(TW) *110*
Terry White Chemists Candesartan (TW) *122*
Terry White Chemists Candesartan HCTZ 16/12.5(TW) *125*
Terry White Chemists Candesartan HCTZ 32/12.5(TW) *125*
Terry White Chemists Candesartan HCTZ 32/25(TW) .. *125*
Terry White Chemists Candesartan(TW) *122*
Terry White Chemists Carvedilol 12.5 mg(TW) *112*
Terry White Chemists Carvedilol 25 mg(TW) *112*
Terry White Chemists Carvedilol 3.125 mg (TW) *112*
Terry White Chemists Carvedilol 6.25 mg(TW) *112*
Terry White Chemists Celecoxib(TW) *564*
Terry White Chemists Citalopram(TW) *637*
Terry White Chemists Clarithromycin(TW) *214*
Terry White Chemists Clindamycin (TW) *216*, *217*
Terry White Chemists Clopidogrel (TW) *87*, *1559*
Terry White Chemists Clopidogrel(TW) *87*
Terry White Chemists Clopidogrel/Aspirin 75/100 (TW) .. *88*
Terry White Chemists Donepezil (TW) *650*, *651*
Terry White Chemists Doxycycline (TW) *200*
Terry White Chemists Doxycycline(TW) *198*, *199*, *200*
Terry White Chemists Duloxetine (TW) *642*
Terry White Chemists Escitalopram(TW) *637*, *638*
Terry White Chemists Fluoxetine (TW) *639*
Terry White Chemists Frusemide(TW) *107*
Terry White Chemists Gliclazide MR (TW) *56*
Terry White Chemists Gliclazide(TW) *57*
Terry White Chemists Indapamide SR (TW) *107*
Terry White Chemists Irbesartan (TW) *123*
Terry White Chemists Irbesartan HCTZ (TW) *126*
Terry White Chemists Irbesartan HCTZ(TW) *126*
Terry White Chemists Irbesartan(TW) *123*
Terry White Chemists Isosorbide Mononitrate (TW) *104*
Terry White Chemists Latanoprost(TW) *687*
Terry White Chemists Lercanidipine(TW) *113*
Terry White Chemists Letrozole (TW) *303*
Terry White Chemists Lisinopril (TW) *116*
Terry White Chemists Meloxicam (TW) *560*
Terry White Chemists Meloxicam 15 mg (TW) *560*
Terry White Chemists Meloxicam 7.5 mg (TW) *560*
Terry White Chemists Metformin (TW) *56*
Terry White Chemists Metformin 1000(TW) *56*
Terry White Chemists Metformin XR 1000 (TW) *56*
Terry White Chemists Metformin XR 500(TW) *56*
Terry White Chemists Metformin(TW) *56*
Terry White Chemists Metoprolol (TW) *111*
Terry White Chemists Mirtazapine (TW) *643*
Terry White Chemists Montelukast(TW) *676*
Terry White Chemists Olanzapine (TW) *619*, *620*
Terry White Chemists Omeprazole (TW) *33*
Terry White Chemists Paroxetine (TW) *640*
Terry White Chemists Perindopril (TW) *117*
Terry White Chemists Perindopril(TW) *116*
Terry White Chemists Perindopril/ Indapamide 4/1.25 (TW) *120*
Terry White Chemists Pioglitazone (TW) *69*
Terry White Chemists Pioglitazone(TW) *69*
Terry White Chemists Pravastatin (TW) *133*, *134*
Terry White Chemists Prazosin (TW) *106*
Terry White Chemists Quetiapine (TW) *624*
Terry White Chemists Quetiapine(TW) *623*
Terry White Chemists Rabeprazole(TW) *35*
Terry White Chemists Ramipril (TW) *117*, *118*
Terry White Chemists Ramipril(TW) *118*
Terry White Chemists Ranitidine (TW) *30*
Terry White Chemists Ranitidine(TW) *30*
Terry White Chemists Rizatriptan (TW) *596*
Terry White Chemists Rosuvastatin (TW) *134*, *135*, *136*
Terry White Chemists Rosuvastatin(TW) *135*, *137*
Terry White Chemists Roxithromycin (TW) *216*
Terry White Chemists Sertraline(TW) *640*
Terry White Chemists Sildenafil(TW) *1568*
Terry White Chemists Simvastatin (TW) *138*, *139*
Terry White Chemists Sumatriptan (TW) *596*, *597*
Terry White Chemists Tramadol SR (TW) *591*
Terry White Chemists Tramadol SR(TW) *591*
Terry White Chemists Tramadol(TW) *591*, *592*
Terry White Chemists Valaciclovir (TW) *233*
Terry White Chemists Valaciclovir(TW) *234*
Terry White Chemists Venlafaxine XR (TW) *644*
Terry White Chemists Zopiclone (TW) *1575*
Tertroxin(QA) *196*
Testogel(HB) *180*
TESTOSTERONE 179
TESTOSTERONE UNDECANOATE 180
TETRABENAZINE 661
TETRACOSACTIDE (TETRACOSACTRIN) 189
TevaGrastim(TB) *841*, *842*, *1077*
Tevaripiprazole(TB) *625*
Tevatiapine XR(TB) *622*, *623*
Teveten Plus 600/12.5(GO) *125*
Teveten(GO) *122*, *123*
THALIDOMIDE 966, 1203
Thalomid(CJ) *967*, *1203*
THEOPHYLLINE 675
TheraTears(CX) *700*
THIAMINE 79, 1557
Thioprine 50 (AF) *556*
Thyrogen(GZ) *189*
THYROTROPIN ALFA 189
THYROXINE 196
TIAGABINE 601
TICAGRELOR 89
Tielle MTL101E(KI) *1590*
Tielle MTL103(KI) *1590*
Tilade CFC-Free(SW) *674*
TIMOLOL 685, 686
Timoptol XE(MF) *685*, *686*
Timoptol(MF) *685*, *686*
Tinaderm(BN) *1561*
Tinasil (AF) *1561*
Tinasil(AF) *162*, *163*
TINIDAZOLE 222
TIOGUANINE 241
TIOTROPIUM 673

TIOTROPIUM + OLODATEROL 671
TIPRANAVIR 1236
TIROFIBAN 89
Tirofiban AC (JO) *90*
Titralac(MM) *1554*
Tivicay(VI) *1248*
Tixol(AL) *642*
TOBI podhaler(NV) *218*
Tobi(NV) *218*
Tobra-Day(PL) *217*
TOBRAMYCIN
.ANTIINFECTIVES FOR SYSTEMIC USE 217, 218
.SENSORY ORGANS 678
Tobramycin AN (EA) *218*
Tobramycin Mylan (AF)
.ANTIINFECTIVES FOR SYSTEMIC USE *217*
Tobrex(NV) *678*
TOCILIZUMAB ... 527, 530, 928, 934, 941, 947, 1164, 1171, 1178, 1183
TOFACITINIB 318, 320
Tofranil 10(GH) *636*
Tofranil 25(GH) *636*
TOLNAFTATE 1561
Topamax Sprinkle(JC) *608*
Topamax(JC) *607*, *608*
TOPIRAMATE 607, 608
Topiramate AN (EA) *607*, *608*
Topiramate GH(GQ) *607*, *608*
Topiramate Sandoz (SZ) *607*, *608*
Topra 40(DO) *34*
Toprol-XL 190(AP) *111*
Toprol-XL 23.75(AP) *111*
Toprol-XL 47.5(AP) *111*
Toprol-XL 95(AP) *111*
TOREMIFENE 300
Torvastat 10(RW) *131*, *132*
Torvastat 20(RW) *131*, *132*
Torvastat 40(RW) *131*, *132*
Torvastat 80(RW) *131*, *132*
Tracleer (AT) *782*, *1018*
Tracleer(AT) *788*, *1023*
Trajenta(BY) *71*
Trajentamet(BY) *63*
TRAMADOL 22, 590, 591, 592
Tramadol ACT(EA) *22*, *590*, *592*
Tramadol AMNEAL (EF) *591*, *592*
Tramadol AN SR (EA) *591*
Tramadol AN SR(EA) *591*
Tramadol AN(EA) *591*, *592*
Tramadol Sandoz (SZ) *22*, *590*, *591*, *592*
Tramadol Sandoz SR (SZ) *591*
Tramadol Sandoz SR(SZ) *591*
Tramadol SCP(CR) *591*, *592*
Tramadol SR generichealth (GQ) *591*
Tramadol SR generichealth(GQ) *591*
Tramal 100(CS) *22*, *590*, *592*
Tramal SR 100(CS) *591*
Tramal SR 150(CS) *591*
Tramal SR 200(CS) *591*
Tramal SR 50(CS) *591*
Tramal(CS) *590*, *591*, *592*
Tramedo (AF) *591*, *592*
Tramedo SR 100 (AF) *591*
Tramedo SR 150 (AF) *591*
Tramedo SR 200(AF) *591*
TRAMETINIB 289
Tranalpha (AF) *119*
Trandate(QA) *112*
TRANDOLAPRIL 119
TRANDOLAPRIL + VERAPAMIL 121
TRANEXAMIC ACID 98
Transiderm-Nitro 25(SZ) *103*
Transiderm-Nitro 50(SZ) *103*
TRANYLCYPROMINE 641
TRASTUZUMAB 244, 245, 246
Travatan(NV) *688*
TRAVOPROST 688
TRAVOPROST + TIMOLOL 688
TRIAMCINOLONE
.DERMATOLOGICALS 165
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS 195
TRIAMCINOLONE + NEOMYCIN SULFATE + GRAMICIDIN + NYSTATIN 707
Triasyn 2.5/2.5(SW) *121*
Triasyn 5.0/5.0(SW) *121*
Tricortone(FM) *165*
Trifeme 28(FZ) *179*
TRIFLUOPERAZINE 615
TRIGLYCERIDES LONG CHAIN 713
TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER 745
TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH GLUCOSE POLYMER 745
TRIGLYCERIDES MEDIUM CHAIN FORMULA
.VARIOUS 726, 727, 745
Trileptal(NV) *600*, *601*
TRIMETHOPRIM 213
TRIMETHOPRIM + SULFAMETHOXAZOLE 213
Triphasil 28(PF) *179*
Triprim(RW) *213*
TRIPTORELIN 298, 1541
Triquilar ED(BN) *179*
Tritace (SW) *118*
Tritace 1.25 mg (SW) *118*
Tritace 10 mg(SW) *118*
Tritace 2.5 mg (SW) *118*
Tritace 5 mg (SW) *118*
Triumeq(VI) *1245*
Trizivir(VI) *1244*
TROPISETRON 40
Tropisetron-AFT(AE) *40*
Trovas (RA) *131*, *132*
Trusamide (QA) *684*
Trusopt(MF) *684*
Truvada(GI) *1246*
Tryzan Caps 1.25 (AF) *118*
Tryzan Caps 10 (AF) *118*
Tryzan Caps 2.5(AF) *118*
Tryzan Caps 5(AF) *118*
Tryzan Tabs 1.25(AF) *118*
Tryzan Tabs 10(AF) *118*
Tryzan Tabs 2.5(AF) *118*
Tryzan Tabs 5(AF) *118*
Tubegauz 0501633(SS) *1582*
Tubifast 2434(MH) *1582*
Tubifast 2436(MH) *1582*
Tubifast 2438(MH) *1582*
Tubigrip 1479(MH) *1583*
Tubigrip 1480(MH) *1583*
Tubigrip 1481(MH) *1583*
Tubigrip 1482(MH) *1583*
Tubigrip 1483(MH) *1583*
Tubigrip 1484(MH) *1583*
Tubigrip 1486(MH) *1583*
Tubigrip B 1520(MH) *1582*
Tubigrip C 1545(MH) *1582*
Tubigrip D 1546(MH) *1582*
Tubigrip E 1547(MH) *1582*
Tubigrip F 1548(MH) *1582*

Twynsta(BY) *129*
Tykerb(NV) *271*
Tylactin RTD(QH) *743*
TYR Anamix infant(SB) *738*
TYR Anamix junior LQ(SB) *734*
TYR Anamix Junior(SB) *738*
TYR cooler 10(VF) *738*
TYR cooler 15(VF) *737*
TYR cooler 20(VF) *737*
TYR Easy Shake & Go(OH) *734*
TYR express 15(VF) *738*
TYR express 20(VF) *737*
TYR gel(VF) *738*
TYR Lophlex LQ 20(SB) *738*
Tyrosine 1000(VF) *746*
TYROSINE WITH CARBOHYDRATE 746
Tysabri(BD) *865*, *1101*
Ulcaid(RA) *30*
ultibro breezhaler 110/50(NV) *670*
UMECLIDINIUM 674
UMECLIDINIUM + VILANTEROL 671
Uracol(EA) *1568*
Ural Sachets (QA) *1568*
UREA 1562
Urederm(KY) *1562*
Uremide (AF) *107*
Urex(RW) *107*
Urex-Forte(RW) *107*
Urex-M(RW) *107*
Uro-Carb(YN) *656*
Uromitexan(BX) *710*
URSODEOXYCHOLIC ACID 43
Ursodox GH (GQ) *43*
Ursofalk(OA) *43*
Ursosan (BZ) *43*
USTEKINUMAB 533, 537, 540, 543, 549, 951, 1188
Utrogestan(HB) *1537*
Vaclovir (AF) *234*
Vaclovir(AF) *233*
Vagifem Low(NO) *182*
VALACICLOVIR 233, 234, 831, 1066
Valaciclovir AN (EA) *233*
Valaciclovir AN(EA) *234*
Valaciclovir generichealth (GQ) *234*
Valaciclovir generichealth(GQ) *233*
Valaciclovir RBX (RA) *233*, *831*, *1067*
Valaciclovir RBX(RA) *234*
Valaciclovir Sandoz (SZ) *234*
Valaciclovir Sandoz(SZ) *233*
Valaciclovir SZ (HX) *233*
Valaciclovir SZ(HX) *233*
Valacor 500 (CR) *233*
Valacor 500(CR) *233*, *234*
Valcyte(RO) *832*, *1067*, *1233*
VALGANCICLOVIR 831, 1067, 1233
Valganciclovir AN (EA) *832*, *1067*, *1233*
Valganciclovir Juno(JU) *832*, *1067*, *1233*
Valganciclovir Mylan (AF) *832*, *1067*, *1233*
Valganciclovir Sandoz(SZ) *832*, *1067*, *1233*
Valine 1000(VF) *746*
Valine 50(VF) *746*
VALINE WITH CARBOHYDRATE 746
Valium(RO) *632*, *759*
Valpam 2 (RW) *632*, *759*
Valpam 5 (RW) *632*, *759*
Valprease 200 (RW) *601*
Valprease 500 (RW) *601*
Valpro EC 200 (AF) *601*
Valpro EC 500 (AF) *601*
VALPROATE 601
Valproate Winthrop EC 200(WA) *601*
Valproate Winthrop EC 500(WA) *601*
VALSARTAN 124
VALSARTAN + HYDROCHLOROTHIAZIDE 127, 128
Valsartan/Amlodipine Sandoz 80/5 (NM) *128*
Valsartan/Amlodipine/HCT Sandoz 160/5/12.5 (NM) *129*
Valtrex(RW) *233*, *234*, *831*, *1067*
Vancocin(AS) *48*
VANCOMYCIN
.ALIMENTARY TRACT AND METABOLISM 47
.ANTIINFECTIVES FOR SYSTEMIC USE 220, 221
Vancomycin Alphapharm (AF)
.ANTIINFECTIVES FOR SYSTEMIC USE *220*, *221*
VARDENAFIL 1568
VARENICLINE 658, 659
Vasafil 100 (RW) *1568*
Vasafil 25 (RW) *1567*
Vasafil 50(RW) *1567*
Vascalace 1.25 (DO) *118*
Vascalace 10 (DO) *118*
Vascalace 2.5 (DO) *118*
Vascalace 5 (DO) *118*
Vascalace Caps 1.25(DO) *118*
Vascalace Caps 10(DO) *118*
Vascalace Caps 2.5 (DO) *118*
Vascalace Caps 5 (DO) *118*
Vasocardol (AV) *114*
Vasocardol CD (AV) *114*, *115*
Vedafil (AF) *1567*
Vedafil(AF) *1567*, *1568*
Vedilol 12.5 (RW) *112*
Vedilol 25 (RW) *112*
Vedilol 3.125(RW) *112*
Vedilol 6.25 (RW) *112*
VEDOLIZUMAB 866, 870, 1102, 1106
Veletri(AT) *792*, *1027*
Velphoro(FN) *709*, *995*, *1231*
VEMURAFENIB 289, 290
Venla RBX (RA) *644*
VENLAFAXINE 644
Venlafaxine AN SR(EA) *644*
Venlafaxine generichealth XR (GQ) *644*
Venlafaxine Sandoz XR(SZ) *644*
Venofer(AS) *98*, *99*
Ventavis(BN) *797*, *1032*
Ventolin CFC-free(GK) *22*, *665*
Ventolin Nebules(GK) *22*, *666*
Ventolin Rotacaps(GK) *666*
Ventolin(GK) *675*
Vepesid(BQ) *242*
VERAPAMIL 114
VERTEPORFIN 697
VESPULA SPP VENOM 708
Vexazone (AF) *69*
Vexazone(AF) *69*
Vfend(PF) *227*, *228*
Viagra (PF) *1568*
Viagra(PF) *1567*
Vidaza(CJ) *837*, *1072*
Videx EC(BQ) *1237*
Viekira Pak(VE) *236*, *834*, *1069*
Viekira Pak-RBV(VE) *236*, *237*, *834*, *835*, *1069*, *1070*
VIGABATRIN 602
VILDAGLIPTIN 73
VILDAGLIPTIN + METFORMIN 66
Vimpat(UC) *603*, *604*
VINORELBINE 242
Viramune (BY) *1243*
Viramune XR (BY) *1242*
Viramune(BY) *1242*

Viread(GI) *1241*
Viscopaste 4948(SN) *1584*
Viscotears Gel PF(IV) *699*
Viscotears(IV) *699*
VISMODEGIB 293
Vistil Forte(AE) *705*, *706*
Vistil(AE) *705*, *706*
Visudyne(NV) *698*
Vita-B12 (GH) *99*
Vita-B12(GH) *1559*
VITAMINS, MINERALS AND TRACE ELEMENTS FORMULA 746
VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE 746, 747
VitA-POS(AE) *704*
Volibris(GK) *777*, *1012*
Volirop 12.5(DO) *112*
Volirop 25(DO) *112*
Volirop 3.125 (DO) *112*
Volirop 6.25(DO) *112*
Voltaren 100(NV) *558*, *751*
Voltaren 25(NV) *558*, *559*, *751*
Voltaren 50(NV) *558*, *559*, *751*
Voluven 6%(PK) *100*
VORICONAZOLE 226, 227, 228
Voriconazole APOTEX (TX) *227*
Voriconazole Sandoz(SZ) *227*
VORINOSTAT 295
Votrient(NV) *278*, *279*, *280*
Voxam (SZ) *639*, *640*
Vttack (AF) *227*
Vytorin(MK) *151*, *152*, *154*
Vyvanse(ZI) *647*
Vzole(RW) *227*
WARFARIN 82
Wartec Cream(GK) *1563*
Waxsol(HM) *1579*
Wellvone(AS) *662*
WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, LONG CHAIN POLYUNSATURATED FATTY ACIDS, VITAMINS AND MINERALS, LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE 747
WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, VITAMINS AND MINERALS, AND LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE 747
WOOL ALCOHOLS 1562
Xalacom(PF) *687*, *688*
Xalamol 50/5 (QA) *687*, *688*
Xalaprost (QA) *687*
Xalatan(PF) *687*
Xalkori(PF) *249*
Xarelto(BN) *95*, *96*, *97*
Xatral SR(SW) *1569*
Xelabine (QA) *241*
Xelabine(QA) *242*
Xeljanz(PF) *320*, *324*
Xelocitabine (JU) *242*
Xelocitabine(JU) *241*
Xeloda(RO) *242*
Xenical(RO) *1557*
Xeomin(EZ) *1260*
Xergic(AF) *1578*
Xgeva(AN) *574*, *575*
Xifaxan(NE) *47*
Xigduo XR 10/1000(AP) *59*
Xigduo XR 10/500(AP) *59*
Xigduo XR 5/1000(AP) *59*
XLYS, LOW TRY Maxamum(SB) *734*
XMET Maxamum(SB) *735*
XMTVI Maxamum(SB) *735*
Xolair(NV) *976*, *977*, *983*, *987*, *1213*, *1214*, *1219*, *1223*
XP Maxamaid(SB) *736*
XP Maxamum(SB) *736*, *737*
XPhen, Tyr Maxamum(SB) *738*
Xtandi(LL) *301*
Xylocaine Viscous(QA) *1563*
Xylocard 500(AS) *101*
Yomax 250(DO) *201*
Yomax 500 (DO) *201*
Z.S.C.(RW) *1566*
Zabep (AL) *35*
Zactin Tablet (AF) *639*
Zactin(AF) *639*
Zan-Extra 10/10(GO) *120*
Zan-Extra 10/20(GO) *120*
Zanidip(GO) *113*
Zantac Syrup(AS) *30*
Zantac(AS) *30*
Zarontin(IX) *598*
Zarzio(SZ) *841*, *842*, *1077*
Zatamil(EO) *171*, *172*, *173*
Zavedos(PF) *242*
Zedace(AF) *115*
Zedd 500(RW) *1570*
Zeffix(RW) *1239*
Zelboraf(RO) *290*
Zeldox (PF) *617*
Zelitrex (RF) *233*, *234*
Zelitrex(RF) *233*, *234*
Zentel(AS) *663*, *664*
Zepatier(MK) *235*, *833*, *1068*
Zerit(BQ) *1239*
Zestril(AP) *116*
ZETIN(RW) *164*
Zetlam(AF) *1239*
Ziagen(VI) *1236*
ZIDOVUDINE 1241
Zilarex(SZ) *1578*
Zilfojim 4 (DO) *38*
Zilfojim 8 (DO) *38*
Zilfojim ODT 4(DO) *40*
Zilfojim ODT 8(DO) *40*
Zimstat (AF) *138*, *139*
Zimstat(AF) *138*, *139*
Zinbryta(BD) *492*
ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN + PURIFIED TALC 1566
ZINC OXIDE + PERU BALSAM + BENZYL BENZOATE 1560
Zinnat (AS) *210*, *211*
Zinnat(AS) *210*, *211*
Zinopril 10(AL) *116*
Zinopril 20(AL) *116*
Zinopril 5(AL) *116*
ZIPRASIDONE 617
ZIPROX(RW) *617*
ZipZoc 66000747(SN) *1584*
Zircol (AF) *113*
Zithromax (PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*
Zithromax(PF)
.Highly Specialised Drugs Program (Private Hospital) *830*
.Highly Specialised Drugs Program (Public Hospital) *1065*
.Repatriation Pharmaceutical Benefits Scheme *1570*
Zithromax(PF)
.ANTIINFECTIVES FOR SYSTEMIC USE *214*
.SENSORY ORGANS *677*

Zitrocin (GN)
.Repatriation Pharmaceutical Benefits Scheme *1570*
Zocor (MK) *138*, *139*
Zofran (AS) *39*
Zofran syrup 50 mL(AS) *38*, *39*
Zofran Zydis(AS) *39*, *40*
Zofran(AS) *38*
ZolaCos CP 10.8/50(28)(AP) *297*
ZolaCos CP 10.8/50(84)(AP) *297*
ZolaCos CP 3.6/50(AP) *297*
Zoladex 10.8 Implant(AP) *296*
Zoladex Implant(AP) *296*
Zoledasta(TX) *569*, *570*
ZOLEDRONIC ACID 569, 969, 1205
Zolinza(MK) *295*
ZOLMITRIPTAN 597
Zoloft(PF) *640*, *641*
Zoltrip (RW) *597*
Zomacton(FP) *1277*, *1327*, *1343*
Zometa(NV) *969*, *1205*
Zomig(AP) *597*
Zonegran (SA) *609*
ZONISAMIDE 608
ZOPICLONE 1575
Zopiclone GH(GQ) *1575*
Zopral ODT(AF) *32*
Zopral(AF) *32*
Zoton FasTabs(PF) *32*
Zovirax 200 mg(GK) *230*
Zovirax(GK) *678*
ZUCLOPENTHIXOL DECANOATE 618
Zumenon(GO) *181*
Zyban(AS) *657*
Zydelig(GI) *291*, *292*
Zydol SR 100(RW) *591*
Zydol SR 150(RW) *591*
Zydol SR 200 (RW) *591*
Zydol(RW) *591*, *592*
Zykadia(NV) *248*
Zyloprim(RW) *566*
Zypine ODT(AF) *620*, *621*, *622*
Zypine(AF) *619*, *620*
Zyprexa Relprevv(LY) *622*
Zyprexa Zydis(LY) *620*, *621*, *622*
Zyprexa(LY) *619*, *620*
Zyrtec(JT) *1578*
Zytiga(JC) *303*