



Subfoveal choroidal neovascularisation Initial PBS authority application Supporting information

Important information

This form must be completed by the treating ophthalmologist.

You must lodge this form for a patient starting **initial** PBS subsidised treatment with ranibizumab and verteporfin for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration.

Medicare Australia needs all requested information on the initial application in order to establish a patient's eligibility for the alternate PBS subsidised agent.

Approval may only be given for one PBS subsidised agent at a time.

All initial applications must be in writing and must include sufficient information to determine the patient's eligibility. **A copy of the fluorescein angiogram must be included.**

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

Ranibizumab applications only

Where a fluorescein angiogram cannot be performed due to a contraindication as listed in the Therapeutic Goods Administration approved product information, details of the contraindication must be provided. A copy of the report of an alternative method of diagnosis must be included in the application, for example optical coherence tomography or red free photography.

Emergency treatments only

To avoid delay in starting treatment the initial application, angiogram report and a copy of the prescription can be faxed to Medicare Australia on **1300 093 177** (call charges may apply). Medicare Australia will then call the prescriber during business hours 8.00 am to 5.00 pm EST Monday to Friday. The original authority application form and angiogram must be mailed to Medicare Australia.

For Department of Veterans' Affairs patients call **1800 552 580**.

Acknowledgements

The patient and the prescriber acknowledgement must be signed in front of a witness (over 18 years of age).

Authority prescription form

A completed authority prescription form must be attached to this form.

The medical indication section of the authority prescription form does not need to be completed when submitted with this form.

Applications for treatment

All applications for verteporfin will be limited to provide for one treatment only.

Applications for ranibizumab can be for the initial treatment and two repeats.

Where both eyes are being treated simultaneously, a quantity of two vials can be requested on the same prescription.

After an application for an initial treatment has been approved, applications for continuing treatment for the same eye can be made in writing or by phone. Call **1800 700 270** (call charges may apply) and select option 3 between 8.00 am to 5.00 pm EST Monday to Friday.

Medicare Australia should be notified if treatment is abandoned before completion of the laser activation step but after infusion of verteporfin. Call **1800 700 270** (call charges may apply) and select option 3 between 8.00 am and 5.00 pm EST Monday to Friday. The reason treatment is abandoned must be provided. Where such a notification has been made, the abandoned treatment will not count towards the maximum amount allowed.

Maximum treatments per eye

Verteporfin – 15 (including prior treatment received under Medicare Benefit Schedule Visudyne Therapy Program).

Assistance

If you need assistance completing this form or need more information call **1800 700 270** (call charges may apply) and select option 3, between 8.00 am to 5.00 pm EST Monday to Friday or go to **www.medicareaustralia.gov.au > For health professionals > PBS > Specialised drugs (PBS) A – I > Age-related macular degeneration**

Lodgement

Send the completed authority application form, completed authority prescription form and all relevant attachments to:

**Medicare Australia
Prior written approval of specialised drugs
Reply Paid 9826
Hobart TAS 7001**

Print in **BLOCK LETTERS**

Tick where applicable



Subfoveal choroidal neovascularisation Initial PBS authority application

Patient's details

1 Medicare/DVA card number
 - - Ref no.

2 Mr Mrs Miss Ms Other
 Family name

 First given name

3 Date of birth
 / /

Appointment details

4 Scheduled appointment
 Date / /
 Time : am/pm

5 Prescriber phone number

Patient's acknowledgement

6 I acknowledge that PBS subsidised treatment with ranibizumab or verteporfin for subfoveal choroidal neovascularisation due to age-related macular degeneration is available as specified by the PBS restrictions and as explained to me by my prescriber.

Patient's signature

Date
 / /

Prescriber's details

7 Prescriber number

8 Family name

 First given name

9 Work phone number

Alternative phone number

Fax number

Prescriber's acknowledgement

10 I have explained:

- the circumstances governing PBS subsidised treatment with ranibizumab and verteporfin for subfoveal choroidal neovascularisation due to age-related macular degeneration.

I believe these to be understood and accepted by the patient.

Prescriber's signature

Date
 / /

Witness's acknowledgement

11 I have witnessed the signatures of **BOTH** the patient and the prescriber.

Witness's full name

Witness's signature (over 18 years of age)

Date
 / /

Treatment details

12 Which agent is this application for?

ranibizumab

verteporfin

13 Has the patient received any treatment under the Medicare Benefit Schedule Visudyne Therapy Program?

No

Yes

a) which eye(s)

right eye left eye

b) number of treatments received

right eye left eye

c) date of last review by Angiogram Review Panel

right eye / /

left eye / /

Conditions and criteria

14 To establish eligibility for PBS authority approval under this criterion the following information must be supplied for the relevant eye(s).

The patient:

has been diagnosed with subfoveal choroidal neovascularisation, due to age-related macular degeneration, by fluorescein angiography

right eye date of report / /

left eye date of report / /

Ranibizumab applications only:

Provide details on contraindication to fluorescein angiogram. A copy of the report of an alternative method of diagnosis must be included in the application.

and either

has predominantly (≥ 50 per cent) classic subfoveal choroidal neovascularisation

right eye left eye

and

has a baseline visual acuity equal to or better than 6/60 (20/200)

right eye left eye

or

is **ONLY** eligible for PBS subsidised ranibizumab as they **do not have both** predominantly (≥ 50 per cent) classic subfoveal choroidal neovascularisation **and** a baseline visual acuity equal to or better than 6/60 (20/200)

right eye left eye

Attachments



Attach a copy of the diagnostic report.

Prescriber's declaration

15 Patient's full name

16 I declare that:

- the information provided on this form is correct.

Prescriber's signature

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Date

 / /

Privacy note

The information provided on this form will be used to assess the eligibility of a nominated person to receive PBS subsidised treatment. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to the Department of Health and Ageing, Department of Veterans' Affairs or as authorised or required by law.