



Acute Lymphoblastic Leukaemia-imatinib mesylate Initial PBS authority application Supporting information

Important information

Complete this form for a patient who is starting **initial** PBS subsidised treatment with imatinib mesylate for acute lymphoblastic leukaemia.

All applications must be in writing and must include sufficient information to determine the patient's eligibility.

Patients are eligible to receive a lifetime **maximum** of 24 months of continuing treatment with imatinib mesylate through the PBS.

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

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.

Phone approvals

Under no circumstance will phone approvals be granted for initial authority applications.

Applications for continuing treatment

All applications for continuing treatment, in combination with chemotherapy, as maintenance of first complete remission of patients, may be made 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.

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 > Acute lymphoblastic leukaemia**

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

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

/ /

Patient's acknowledgement

4 I acknowledge that PBS subsidised treatment with imatinib mesylate in combination with chemotherapy, for acute lymphoblastic leukaemia will stop:

- if subsequent testing demonstrates that I have failed to achieve or maintain first complete remission
- after I have received a lifetime maximum of 24 months of continuing treatment for which I was eligible.

My prescriber has explained the nature of the ongoing monitoring and testing required to demonstrate an adequate response to therapy.

Patient's signature

Date

/ /

Prescriber's details

5 Prescriber number

6 Family name

First given name

7 Work phone number

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Alternative phone number

Fax number

()


Prescriber's acknowledgement

8 I have explained:

- the circumstances governing PBS subsidised treatment with imatinib mesylate in combination with chemotherapy, for acute lymphoblastic leukaemia
- the nature of the ongoing monitoring and testing required to demonstrate the first complete remission
- that the patient is eligible for a lifetime **maximum** of 24 months of continuing treatment with imatinib mesylate.

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

Prescriber's signature



Date


/ /

Witness's acknowledgement

9 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

/ /

Conditions and criteria

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

The patient:

has signed the patient acknowledgement

and

will be treated with imatinib mesylate in combination with chemotherapy

and immediately before starting treatment with imatinib mesylate has/had

newly diagnosed acute lymphoblastic leukaemia demonstrated on pathology report of bone marrow or blood

and

a pathology cytogenetic report supporting the presence of the Philadelphia chromosome


or

a qualitative PCR report documenting the presence of the *BCR-ABL* transcript.

Provide dates of treatment for patients previously treated with imatinib mesylate under the Imatinib Compassionate Program.

From / / to / /

Attachments


 Attach all relevant pathology reports and a completed authority prescription form.

Prescriber's declaration

11 I declare that:

- the information provided on this form is correct.

Prescriber's signature



Date

/ /

Privacy note

The information provided on this form will be used to assess applications and eligibility for the 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.