



# Teriparatide Initial PBS authority application Supporting information

## Important information

You must lodge this form for a patient starting **initial** treatment with teriparatide as the sole PBS subsidised treatment for severe osteoporosis.

All applications must be completed by a specialist or consultant physician and must be in writing and include sufficient information to determine the patient's eligibility according to the PBS criteria.

Details of prior anti-resorptive therapy, fracture history including the date(s), site(s), the symptoms associated with the fracture(s) which developed during the course of anti-resorptive therapy and the date and T-score of the qualifying bone mineral density (BMD) measurement must be provided.

A vertebral fracture is defined as a 20 per cent or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20 per cent or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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

Teriparatide must only be used for a lifetime maximum of 18 months therapy (18 pens). Applications for PBS subsidised treatment with teriparatide that extends beyond 18 months therapy will not be approved.

## Acknowledgements

The patient and 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.

## Assistance

If you need assistance completing this form, or for applications relating to continuing treatment call **1800 700 270** (call charges may apply) and select option 2, between 8.00 am to 5.00 pm EST, Monday to Friday or go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For health professionals > PBS > Specialised drugs (PBS) J-Z > Osteoporosis-teriparatide**

## Lodgement

Send the completed authority application form and a completed authority prescription form to:

**Medicare Australia**

**Prior written approval of specialised drugs**

**Reply Paid 9826**

**Hobart TAS 7001**

Print in **BLOCK LETTERS**

Tick where applicable



# Teriparatide 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  
 /  /

## Patient's acknowledgement

**4** I acknowledge that PBS subsidised treatment with teriparatide for severe, established osteoporosis will stop after:

- I have received 18 months (18 pens) of lifetime therapy.

Patient's signature

Date  
 /  /

## Prescriber's details

**5** Prescriber number

**6** Family name  
  
 First given name

**7** Work phone number

Alternative phone number

Fax number

## Prescriber's acknowledgement

**8** I have explained:

- the circumstances governing PBS subsidised treatment with teriparatide for severe, established osteoporosis.

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  
 /  /

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## Conditions and criteria

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

The patient:

will be treated with teriparatide as the sole PBS subsidised agent for osteoporosis

has severe, established osteoporosis

has a bone mineral density (BMD) T-score of -3.0 or less

• provide the qualifying T-score measurement and date  
 / /

has had two or more fractures due to minimal trauma

has experienced at least one symptomatic new fracture after at least 12 months continuous therapy with an anti-resorptive agent at adequate doses

- details of anti-resorptive treatment

Name of drug

from  / /  to  / /

Name of drug

from  / /  to  / /

Name of drug

from  / /  to  / /

- details on contraindications or intolerance including the degree of toxicity. Intolerance must be of a severity to necessitate permanent treatment withdrawal

Contraindication or toxicity and grade


- details of fracture(s) which developed after at least 12 months continuous therapy with an anti-resorptive agent at an adequate dose

Date(s)

 / /  / / 

Site(s)


Symptoms


**and** (if applicable)

has received prior teriparatide treatment

- provide date treatment with teriparatide started  
 / /
- provide the number of months of therapy (pens) the patient has received.

## Attachments



Attach a completed authority prescription form.

## Prescriber's declaration

**11** 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 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.