Australian Government
Department of Human Services

medicare

PBS

Growth hormone deficiency – adult initial PBS authority application

When to use this form

Use this authority application form (this form) to apply for **initial** Pharmaceutical Benefits Scheme (PBS) subsidised somatropin for an adult patient with severe growth hormone deficiency.

Important information

Initial applications to start PBS subsidised treatment must be in writing and must include sufficient supporting information to determine the patient's eligibility according to the PBS criteria.

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

The patient must be treated by an endocrinologist.

The baseline serum IGF-1 measurement, and Quality of Life (QoL) score on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA) instrument must be no more than 12 weeks old prior to initiating treatment.

Grandfathered patients must have met all the initial restriction criteria prior to initiating non-PBS subsidised treatment.

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

Continuing treatment

This form is ONLY for **initial** treatment.

Applications for continuing treatment must be made in writing and submitted to the Australian Government Department of Human Services for those patients who meet the criteria.

For more information

Go to **humanservices.gov.au/healthprofessionals**

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Patient's details

1 Medicare card number

[ ][ ][ ][ ] – [ ][ ][ ][ ][ ] – [ ] Ref no. [ ]

or

Department of Veterans' Affairs card number

[ ]

2 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name

[ ]

First given name

[ ]

3 Date of birth

[/ /]

Prescriber's details

4 Prescriber number

[ ]

5 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name

[ ]

First given name

[ ]

6 Business phone number

( )

Alternative phone number

[ ]

Fax number

( )

Conditions and criteria

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

7 Is the patient being treated by an endocrinologist?

No ☐

Yes ☐

8 Has the patient previously received non-PBS subsidised therapy with somatropin for adult growth hormone deficiency prior to **1 December 2018**?

No ☐

Yes ☐

9 The patient:

☐ has a documented childhood onset growth hormone deficiency due to a:

- ☐ congenital cause

or

- ☐ genetic cause

or

- ☐ structural cause

or

☐ has adult onset growth hormone deficiency secondary to:

- ☐ organic hypothalamic disease

or

- ☐ pituitary disease.

10 The patient:

☐ has an insulin tolerance test with maximum serum GH < 2.5 µg/L

or

☐ has an arginine infusion test with maximum serum GH < 0.4 µg/L

or

☐ has a glucagon provocation test with maximum serum GH < 3 µg/L.

Provide corresponding growth hormone simulation test result:

Peak GH concentration level [ ]

Laboratory reference range for age and sex [ ]

Date of testing [/ /]

11 Provide the patients baseline IGF-1 results:

Baseline serum IGF-1 measurement

Laboratory reference range for age and sex

Date of testing / /

The results must be less than 12 weeks old at time of initiating treatment.

12 Provide the patient's baseline QoL on the QoL-AGHDA instrument:

QoL score

Date of testing / /

The results must be less than 12 weeks old at time of initiating treatment.

13 Provide the patient's somatropin dose per day

/day

Checklist

14 The relevant attachments need to be provided with this form.

☐ The completed authority prescription form(s).

Privacy notice

15 Personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the purposes of assessing and processing this authority application.

Personal information may be used by the department, or given to other parties where the individual has agreed to this, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

More information about the way in which the department manages personal information, including our privacy policy, can be found at **humanservices.gov.au/privacy**

Prescriber's declaration

16 I declare that:

- I am aware that this patient must meet the criteria listed in the current Schedule of Pharmaceutical Benefits to be eligible for this medicine.
- I have informed the patient that their personal information (including health information) will be disclosed to the Australian Government Department of Human Services for the purposes of assessing and processing this authority application.
- I have provided the completed authority prescription form(s) and the relevant attachments as specified in the Pharmaceutical Benefits Scheme restriction.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Prescriber's signature

On completion, print and sign by hand.

Date / /

Reset form Print form

Returning your form

You can return this form and any supporting documents:

- **Online**, upload this form, the authority prescription form(s) and any relevant attachments through Health Professional Online Services (HPOS) at **humanservices.gov.au/hpos**
- **By mail**, send this form, the authority prescription form(s) and any relevant attachments to:

Department of Human Services
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001