NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

NSW HEALTH USE ONLY

APPLICATION FOR AUTHORITY TO PRESCRIBE OR SUPPLY METHADONE, BUPRENORPHINE OR OTHER OPIOID AGONIST THERAPY (OAT) TREATMENT UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP)

Poisons and Therapeutic Goods Act 1966 (NSW)

SMR130051

Are you:

An addiction medicine specialist, addiction psychiatrist, or an accredited Opioid Treatment Program (OTP) prescriber
Addiction medicine specialists or accredited OTP prescribers are generally allowed to manage up to 200 patients who dose in community pharmacies or private clinics, or up to 300 patients who dose in public OTP clinics.

A non-accredited prescriber

A NSW practitioner who is not an Opioid Treatment Accreditation Course (OTAC) accredited NSW OTP prescriber may be authorised by the NSW Ministry of Health to manage up to 30 patients including:

- a maximum of 10 patients treated with **methadone** who are referred by an accredited OTP prescriber for continued dosing
- a maximum of 20 patients treated with **buprenorphine** or **buprenorphine-naloxone**, who may be inducted by a non-accredited prescriber or referred by an accredited OTP prescriber.

Before starting the application

Please make sure that you have:

- **Contacted the authorised OTP prescriber** if the patient is currently enrolled in the OTP and ensured that the prescriber has exited the patient from their current OTP or has a confirmed exit date
- **Obtained a second opinion supporting OTP treatment** if the patient is under 18 years of age
- **Obtained a second opinion supporting the use of other Opioid Agonist Therapy (OAT) Treatment** if prescribing or supplying OAT treatment **(See Section E).**

Clinical Advice and Support:

*The NSW Ministry of Health recommends the use of **SafeScript NSW** to assist practitioners to make informed clinical decisions https://www.safescript.health.nsw.gov.au/. Consider checking **SafeScript NSW** for evidence of alerts or other issues related to the prescribing and supply of high-risk monitored medicines.*

*The NSW Ministry of Health requires that prescribing is in accordance with the **NSW Clinical Guidelines: Treatment of opioid dependence** available at: http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2018_019, and the **Clinical Guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence** https://www.health.nsw.gov.au/aod/Pages/brief-depot-bupe-gl.aspx*

*The NSW Ministry of Health recommends all OTP prescribers complete the **Fundamentals of Training and Opioid Treatment Accreditation Course**. To become an accredited OTP prescriber in NSW completion of the full OTAC course is required https://otac.org.au/*

*Applicants can contact experienced clinical advisors and addiction medicine specialists to obtain general clinical advice and support when managing patients with drug and alcohol issues, by calling the free **Drug & Alcohol Specialist Advisory Service (DASAS) on Metropolitan Area: (02) 8382-1006; Regional, Rural & Remote NSW: 1800 023 687**, available 24/7. **This advice line cannot provide support for an application for an authority.***

Privacy Statement: *The information set out in this form is required by the NSW Ministry of Health for the issuance of an authority to prescribe or supply a Schedule 8 medicine as required under the law. The collection, use and disclosure of the information provided will be in accordance with privacy laws. Information collected as part of the application process may be used and disclosed as part of assessing the application. Medicare numbers may be used for the purpose of patient identification. Practitioner information, and data regarding the number of patients for whom they hold authorities to prescribe or supply a Schedule 8 medicine, may also be used and disclosed for policy and planning purposes. The information collected may be disclosed to health practitioners when necessary to facilitate coordination of treatment and patient safety or where required or authorised by law. The application may not be processed if all information and all declarations requested on the form are not completed. For further information on privacy, visit* **http://www.health.nsw.gov.au/patients/privacy**

☐ **I confirm that I have read and understood all the information above including 'Clinical Advice and Support' and the 'Privacy Statement'**

(This declaration is mandatory and must be completed)

Enquiries: Please direct any enquiries to the Pharmaceutical Regulatory Unit: Tel: **(02) 9424 5921** or email: MOH-OTP@health.nsw.gov.au

Submitting the application:
Fax the completed form to the Pharmaceutical Regulatory Unit: **(02) 9424 5885** or email to MOH-OTP@health.nsw.gov.au

Processing Time: Please allow **2 business days** for the processing of applications. ***Please note***: *For patients under 16 years, treatment of any condition other than ADHD, narcolepsy and medical treatment of cancer requires an exemption under the Children and Young Persons (Care and Protection) Act 1998. A medical practitioner may request an exemption be sought from the Secretary, Department of Community and Justice by the Secretary, NSW Ministry of Health. Please allow additional application processing time if the above circumstances apply. Contact the Pharmaceutical Regulatory Unit for any additional information and to check on the progress of your application.*

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SMR130.051

NH700459A 230823

NSW Health

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Section A Prescriber Details

Prescriber Name *(as displayed in AHPRA)*			
	Given Name(s)	Middle Name(s)	Family Name
Name of Practice			
Address			
Suburb/Town		Postcode	
Telephone		Fax	Mobile
Email *(please note this email address will be used for all correspondence)*			
AHPRA Registration No.		PBS Prescriber No.	

Section B Patient Details

Patient Name *(as shown on Medicare card)*			
	Given Name(s)	Middle Name(s)	Family Name
Patient also known as *(if applicable)*			
	Given Name(s)	Middle Name(s)	Family Name
Address			
Suburb/Town		Postcode	
Medicare number *(if applicable)*	_____ Ref no. _____		
DVA number *(if applicable)*	_____		
Date of Birth (*dd/mm/yyyy*)	_____/_____/_____	Sex ☐ M ☐ F ☐ Another term ☐ Not Stated	

I confirm that I have positively identified the patient using appropriate form(s) of identification: ☐ Yes ☐ No

Section C Additional Patient Information

1. Is the patient of Aboriginal or Torres Strait Islander origin *(tick one box only)*

☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander
☐ Yes, both Aboriginal and Torres Strait Islander
☐ No, neither Aboriginal nor Torres Strait Islander

2. What is the patient's primary opioid drug of dependence? *(tick one box only)*

☐ Heroin
☐ Oxycodone
☐ Methadone
☐ Morphine
☐ Fentanyl
☐ Hydromorphone
☐ Pethidine
☐ Tapentadol
☐ Tramadol
☐ Codeine
☐ Buprenorphine
☐ Other, *specify:*

3. Other drug(s), of concern? *(tick all appropriate boxes)*

☐ No other drugs of concern
☐ Alcohol
☐ Benzodiazepines
☐ Cocaine
☐ Cannabinoids
☐ Pregabalin
☐ MDMA (e.g. ecstasy)
☐ Methamphetamine
☐ Nicotine
☐ Non-opioid analgesics
☐ Other, *specify:*

NO WRITING

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4. Indicate the patient's status: *(tick one box only)*

☐ Currently on OTP ***(Go to Question 5)***

☐ Not currently on OTP but has previously been on OTP ***(Go to Question 6)***

☐ Never been on OTP ***(Go to Section D)***

5. Who is the patient's current OTP prescriber? *(tick one box only)*

☐ I (the applicant) am the current prescriber ***(Go to Section D)***

☐ Correctional Facility (public or private) prescriber ***(Go to Question 6)***

☐ Other NSW community prescriber, *specify full name:* _____ ***(Go to Question 6)***

☐ Interstate or Overseas prescriber, *specify (e.g. Vic):* _____ ***(Go to Question 6)***

6. Date of last dose of methadone/buprenorphine: _____/_____/_____

If the patient is transferring from another prescriber, specify the date of the last dose dispensed on the current prescription, including any takeaways

Section D Drug and Dose Information

- ***Section D must be completed if prescribing or supplying methadone or buprenorphine***
- *Addiction medicine specialists, addiction psychiatrists or OTP accredited nurse practitioners (in public hospitals and Justice Health & Forensic Mental Health Network (JHFMHN only) intending to use a Transfer Protocol complete both Section D and E*

This application is for *(tick one box only)*:

☐ Methadone

☐ Buprenorphine (sublingual administration)

☐ Buprenorphine-naloxone (sublingual administration)

☐ Depot buprenorphine (subcutaneous injection) (includes the use of sublingual doses for induction and supplementation)

Authorities issued for buprenorphine will allow all forms of buprenorphine to be prescribed and/or supplied

Proposed starting date: _____/_____/_____ Expected starting dose: _____ mg

Expected maximum dose: _____ mg

For doses exceeding the equivalent of 200mg per day of methadone or 32mg per day of buprenorphine (sublingual) use Application for Authority to Prescribe or Supply Methadone (>200mg/day) or Buprenorphine (>32mg/day)

If prescribing a transfer protocol go to Section E, all other applicants go to Section F: Administration (dosing) point

Section E Other Treatment & Transfer Protocols

Transfer Protocol

ONLY to be completed, if required, by:

- ***Addiction medicine specialists*** ***Addiction psychiatrists*** ***OTP accredited medical practitioners***
- ***OTP accredited nurse practitioners*** *(in public hospitals and Justice Health & Forensic Mental Health Network (JHFMHN) only)*

☐ **Microdose transfer from methadone to buprenorphine**

Specify date range of transfer treatment (not to exceed 14 days) *from:* _____/_____/_____ *to:* _____/_____/_____

☐ **Bridging transfer from methadone to buprenorphine using a short-acting opioid** *e.g. oxycodone*

Specify drug: _____ *Specify expected maximum dose:* _____*mg*

Specify date range of transfer treatment (not to exceed 14 days) *from:* _____/_____/_____ *to:* _____/_____/_____

Go to Section F: Administration (dosing) point

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Other Opioid Agonist Therapy (OAT) Treatment

ONLY to be completed, if required, by:

- ***Addiction medicine specialists***
- ***Addiction psychiatrists***
- ***Other appropriate accredited practitioners***

☐ **I declare an alternate OAT is appropriate for the patient as methadone or buprenorphine is not suitable (for example when the prescribing of methadone or buprenorphine is contraindicated). I have obtained a second opinion from an addiction medicine specialist supporting this treatment**

(Tick one box only)

☐ Morphine ☐ Hydromorphone ☐ Oxycodone ☐ Other *(specify drug):* _____

Route of administration: _____ Expected maximum daily dose: _____ mg

Proposed starting date: _____/_____/_____

Go to Section F: Administration (dosing) point

Section F Administration (dosing) Point

Proposed administration (dosing) point name: _____

Suburb/Town: _____

Note: Opioid Treatment line (OTL) 1800 642 428 can be contacted for registered dosing points in NSW. Please contact the chosen dosing point and confirm availability for new patients

Section G Declaration

☐ **I confirm that the information I have provided in this application is true and complete to the best of my knowledge.**

☐ **I declare I have read and agree to comply with NSW Clinical Guidelines: Treatment of Opioid Dependence and/or the Clinical Guidelines for use of depot buprenorphine in the treatment of opioid dependence issued by the NSW Ministry of Health.**

The patient's opioid dependence has been established using current best practice and the patient has been assessed suitable for the OTP. Copies of i) Patients' rights and responsibilities and ii) Service provider/clinician responsibilities have been provided to the patient.

The patient has been informed of the reasons for collecting their personal health information, how it may be used, and who it may be disclosed to (according to the Privacy Statement on page 1)

Print & Sign

Signature: _____ Date: _____/_____/_____

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

SMR130051

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