NSW GOVERNMENT | Health

OTP07/16

Application for Authority to Prescribe Methadone or Buprenorphine under the NSW Opioid Treatment Program (OTP)

This form is available online in PDF format (http://www.health.nsw.gov.au/pharmaceutical) and should be filled in electronically using a computer. If completing the form by hand, please use BLOCK LETTERS and ensure that all details are legible.

Eligible applications are generally processed within 2 business days.

Patient ID No : START DATE : TRANSFER : Y / N *[OFFICE USE ONLY]*

1. PATIENT FAMILY NAME : ....

2. GIVEN NAMES : ....
   (first and middle)

3. ALSO KNOWN AS : ....
   (family name)
   ....
   (first and middle name)

4. RESIDENTIAL ADDRESS : ....
   ....

5. SUBURB : ....

6. POSTCODE : ___ ___ ___ ___

7. DATE OF BIRTH : ___ ___ ___ ___ ___ ___ ___ ___
   If patient is aged 16 years to under 18 years, provide the name of the approved prescriber providing a second opinion. A report from this prescriber must be attached to this application.
   ....

8. SEX : ☐ M ☐ F

9. This application is for : ☐ Methadone ☐ Buprenorphine

10. Indicate the patient's current status : *(Tick one box only)*
    - ☐ Currently on NSW OTP ⇨ *GO TO Q.16*
    - ☐ Not currently on NSW OTP but has previously been on NSW OTP
    - ☐ Never has been on NSW OTP

11. Is the patient of Aboriginal or Torres Strait Islander origin?
    - ☐ 1 Yes, Aboriginal
    - ☐ 2 Yes, Torres Strait Islander
    - ☐ 3 Yes, both Aboriginal and Torres Strait Islander
    - ☐ 4 No, neither Aboriginal and Torres Strait Islander

12. In which COUNTRY was the patient born?
    - ☐ 1100 Australia
    - ☐ other, *specify* ....

13. What is the patient's PREFERRED LANGUAGE?
    - ☐ 1201 English
    - ☐ other, *specify* ....

14. What is the patient's primary opioid drug of dependence? *(Tick one box only)*
    - ☐ 1202 heroin
    - ☐ 1203 oxycodone
    - ☐ 1101 codeine
    - ☐ 1201 buprenorphine
    - ☐ 1305 methadone
    - ☐ 1102 morphine
    - ☐ 1301 fentanyl
    - ☐ 1210 hydromorphone
    - ☐ 1306 pethidine
    - ☐ 9999 other, *specify* ....

15. What drug(s), other than opioids, does the patient perceive as being a concern? *(Tick the appropriate box/es)*
    - ☐ 3 no other drugs of concern
    - ☐ 2100 alcohol
    - ☐ 2400 benzodiazepines
    - ☐ 3903 cocaine
    - ☐ 7101 cannabinoids
    - ☐ 2202 ketamine
    - ☐ 3405 MDMA (e.g. ecstasy)
    - ☐ 3103 methamphetamine
    - ☐ 3906 nicotine
    - ☐ 1400 non opioid analgesic
    - ☐ 9999 other, *specify* ....

16. Who is the patient's current OTP prescriber? *(Tick one box only)*
    - ☐ Patient is not currently on the NSW OTP ⇨ *GO TO Q.19*
    - ☐ I (the applicant) am the current prescriber
    - ☐ Other NSW community prescriber, *specify full name*
      ....
    - ☐ Justice Health
    - ☐ Interstate or Overseas prescriber, *specify (e.g. Vic)*
      ....

    Note: A statement signed by the interstate prescriber showing the dose and date of last dose (including takeaways) must be attached to this application

17. Date of last dose of methadone/buprenorphine :
    Note: If the patient is transferring from another prescriber, specify the date of the last dose dispensed on the current prescription, including any takeaways.

    ___ ___ ___ ___ ___ ___ ___ ___

Patient's Name:...*(prescriber to complete)*

18. Last dose of methadone/buprenorphine : ___ ___ ___ mg
19. Proposed starting date : ___ ___ ___ ___ ___ ___ ___ ___
20. Proposed starting dose (determined in accord with clinical assessment) : ___ ___ ___ mg
21. Has treatment been commenced as an inpatient immediately prior to this application? ☐ Y ☐ N
22. Expected maximum dose : ___ ___ ___ mg
23. Proposed administration (dosing) point :

....

....

Suburb/Town : ....

I, the undersigned, declare that the patient's opioid dependence has been established using current best practice (see latest NSW clinical guidelines issued by the Ministry of Health), and that the patient has been assessed suitable for the OTP. A treatment agreement has been completed.

Prescriber's Signature : ....

Prescriber's Name : ....

AHPRA Registration Number : ....

PBS Prescriber Number : ....

Best Contact Number : ....

Practice Name : ....

Practice Address : ....

Ph : .... Fax : ....

To be completed by the patient

I hereby declare that I have not knowingly supplied any false particulars above and that I am *NOT CURRENTLY ON ANY OTHER /TRANSFERRING FROM ANOTHER methadone or buprenorphine program. I have been explained the nature of methadone/buprenorphine treatment and the potential side effects of methadone/buprenorphine, and I consent to treatment. I also understand that the particulars I have supplied are relevant and necessary to my treatment and the management of the NSW Opioid Treatment Program, and will be stored confidentially on a central register.

Name : ....

Signature : ....

Date : ___ ___ ___ ___ ___ ___ ___ ___

**Cross out whichever does not apply*

Privacy Statement:
The information set out in this form is required for the issuance of an authority to prescribe a Schedule 8 drug as required under the law. The collection, use and disclosure of the information provided will be in accordance with privacy laws. The information collected may be disclosed to health practitioners when necessary to facilitate coordination of treatment and patient safety. Personal information will not be disclosed for any other purpose without prior consent, except where required by law or where otherwise lawfully authorised to do so. The application may not be processed if all information requested on the form is not completed. For further information on privacy please visit http://www.health.nsw.gov.au/patients/privacy
For further advice or clarification please email pharmserv@doh.health.nsw.gov.au

Fax completed form (and any required supporting documents) to the Pharmaceutical Regulatory Unit: **(02) 9424 5885**

For enquiries, telephone (02) 9424 5921 during business hours.