NSW Health

Application for Authority to Prescribe or Supply a Schedule 8 Medicine - Alprazolam or Flunitrazepam

as required under the Poisons and Therapeutic Goods Act 1966 (NSW)

Before starting the application, please make sure that you have:

- **Contacted the authorised Opioid Treatment Program prescriber** if the patient is currently enrolled on the Opioid Treatment Program (OTP) and have obtained written agreement from the OTP prescriber for benzodiazepine treatment.
- **Sought a review and second opinion from an appropriate medical specialist** if:
  - the indication for use is not listed in the approved Product Information (PI)
  - the prescribed dose exceeds that specified in the PI
  - treatment with a benzodiazepine has exceeded the duration recommended in the PI
  - the prescriber is not a psychiatrist or respiratory and sleep medicine specialist (flunitrazepam) and is initiating or continuing treatment.

Where possible the second opinion should be in writing from an appropriate medical specialist independent of the prescriber.

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 or supply of high-risk monitored medicines.

Applicants can contact experienced clinical advisors and can access relevant medical specialists to obtain general clinical advice and support when managing patients, by calling the free ***SafeScript NSW Clinical Advice Line (SCAL)*** on ***1800 434 155***, available 24/7. **This advice line cannot provide support for an application for an authority.**

Applicants are advised to consider if the patient would benefit from a review by an **addiction medicine specialist** to manage any perceived drug dependence concerns.

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)

Submitting the application:

Fax completed form to the Pharmaceutical Regulatory Unit: Fax: **(02) 9424 5889** or email to: MOH-S8Auth@health.nsw.gov.au

Enquiries:

Please direct any enquiries to the Pharmaceutical Regulatory Unit: Tel: **(02) 9424 5923** email: MOH-S8Auth@health.nsw.gov.au

Processing Time:

Please allow up to **7 business days** for the processing of applications.

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SECTION A – Prescriber Details

Prescriber Name: (as displayed in AHPRA)

First Name: _____ 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)

First Name: _____ Middle Name(s): _____

Family Name: _____

Patient also known as: (if applicable)

First Name: _____ Middle Name(s): _____

Family Name: _____

Address: _____ Suburb/town: _____

Postcode: _____ Medicare number: (if applicable) _____ Ref no.: _____

DVA number: (if applicable) _____

DOB: _____ (dd/mm/yyyy) Sex: ☐ Male ☐ Female ☐ Another term

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SECTION C – IS AN AUTHORITY REQUIRED?

1. DO YOU CONSIDER THIS PATIENT TO BE DRUG DEPENDENT?

A 'drug dependent person' means a person who has acquired, as a result of repeated administration of:

(a) a drug of addiction, or

(b) a prohibited drug within the meaning of the Drug Misuse and Trafficking Act 1985,

an overpowering desire for the continued administration of such a drug. **(section 27 of the Poisons and Therapeutic Goods Act 1966).**

- ☐ **Yes**. **Authority required.** Go to question 2
- ☐ **No**. Go to question 3

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2. IS THE PATIENT CURRENTLY ENROLLED ON THE OPIOID TREATMENT PROGRAM (OTP)

- ☐ **No**. Go to **Section D: Alprazolam** or **Section E: Flunitrazepam**
- ☐ **Yes**. **I am the authorised OTP prescriber**. Go to **Section D: Alprazolam** or **Section E: Flunitrazepam**
- ☐ **Yes**. **I am NOT the authorised OTP prescriber.** Has the patient been reviewed by the authorised OTP prescriber and written agreement to the proposed treatment obtained?
  - ☐ **Yes**. Go to **Section D: Alprazolam** or **Section E: Flunitrazepam**
  - ☐ **No**. Contact the authorised OTP prescriber and obtain written agreement before submitting this application. **This application cannot proceed** and will not be considered until written agreement is obtained.

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3. IF THE PATIENT IS NOT CONSIDERED TO BE DRUG DEPENDENT, HAVE THEY USED OR ARE THEY EXPECTED TO USE THE MEDICINE CONTINUOUSLY FOR MORE THAN TWO MONTHS?

- ☐ **Yes**. **Authority required.** Go to **Section D: Alprazolam** or **Section E: Flunitrazepam**
- ☐ **No**. **Authority is NOT required** for this patient at this time. Prescribing may continue without authority from NSW Ministry of Health

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SECTION D – ALPRAZOLAM

IF YOU ARE A PSYCHIATRIST, GO TO 'DOSAGE'

For all other prescribers, please complete this section.

Is the patient currently being prescribed or supplied alprazolam?

☐ **No**. Has the patient been reviewed by a **psychiatrist** and **written support obtained for the proposed treatment?**

- ☐ **Yes**. Go to '**Dosage**'
- ☐ **No**. Refer the patient to a psychiatrist and obtain written support. This application **cannot proceed** and will not be considered until written support is obtained.

☐ **Yes**. Has the patient been reviewed by a **psychiatrist** and **written support obtained for the proposed treatment?**

- ☐ **Yes**. Go to '**Dosage**'
- ☐ **No**. Refer the patient to a psychiatrist and obtain written support. Go to '**Dosage**'

DOSAGE

Maximum daily dose: _____ mg

If the dose is in excess of **4mg** daily:

Has the patient been reviewed by an independent **psychiatrist** and do you have written support for treatment at a **high dose?**

☐ **Yes**. Go to '**Indications for Prescribing or Supply**'

☐ **No**. Refer the patient to a **psychiatrist** and obtain written support for treatment at a high dose. Go to '**Indications for Prescribing or Supply**'

INDICATIONS FOR PRESCRIBING OR SUPPLY

☐ **Generalised anxiety disorder** ☐ **Panic attacks** ☐ **Panic disorder** Go to **Section F: Declaration**

☐ **Other** _____ (please specify)

Has the patient been reviewed by an independent **psychiatrist** and do you have written support for an **indication not specified in the approved Product Information?**

- ☐ **Yes**. Go to **Section F: Declaration**
- ☐ **No**. Refer the patient to a psychiatrist and obtain written agreement. Go to **Section F: Declaration**

The NSW Ministry of Health recommends that all prescribing or supply of this medicine is in accordance with the approved Product Information (PI) and with published recommendations from the RANZCP and RACGP with regard to benzodiazepines. Treatment should be in accordance with a treatment management plan, which should consider all available treatment options, including non-pharmacological strategies.

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SECTION E – FLUNITRAZEPAM

IF YOU ARE A RESPIRATORY AND SLEEP MEDICINE SPECIALIST OR PSYCHIATRIST, GO TO 'DOSAGE'

For all other prescribers, please complete this section.

Is the patient currently being prescribed or supplied flunitrazepam?

☐ **No**. Has the patient been reviewed by a **respiratory and sleep medicine specialist** or **psychiatrist** and **written support obtained for the proposed treatment?**

- ☐ **Yes**. Go to '**Dosage**'
- ☐ **No**. Refer the patient to a respiratory and sleep medicine specialist or psychiatrist and obtain written support. This application **cannot proceed** and will not be considered until written support is obtained.

☐ **Yes**. Has the patient been reviewed by a **respiratory and sleep medicine specialist** or **psychiatrist** and **written support obtained for the proposed treatment?**

- ☐ **Yes**. Go to '**Dosage**'
- ☐ **No**. Refer the patient to a respiratory and sleep medicine specialist or psychiatrist and obtain written agreement. Go to '**Dosage**'

DOSAGE

Maximum daily dose: _____ mg

If the dose is in excess of **2mg** daily or **1mg** daily for elderly patients – 65 years or older:

Has the patient been reviewed by an independent **respiratory and sleep medicine specialist** or **psychiatrist** and do you have written support for treatment at a **high dose?**

☐ **Yes**. Go to '**Indications for Prescribing or Supply**'

☐ **No**. Refer the patient to a **respiratory and sleep medicine specialist** or **psychiatrist** and obtain written agreement for treatment at a high dose. Go to '**Indications for Prescribing or Supply**'

INDICATIONS FOR PRESCRIBING OR SUPPLY

☐ **Severe insomnia** Go to **Section F: Declaration**

☐ **Other** _____ (please specify)

Has the patient been reviewed by an independent **respiratory and sleep medicine specialist** or **psychiatrist** and do you have written support for an **indication not specified in the approved Product Information?**

- ☐ **Yes**. Go to **Section F: Declaration**
- ☐ **No**. Refer the patient to a **respiratory and sleep medicine specialist** or **psychiatrist** and obtain written support. Go to **Section F: Declaration**

The NSW Ministry of Health recommends that all prescribing or supply of this medicine is in accordance with the approved Product Information (PI) and with published recommendations from the RANZCP and RACGP with regard to benzodiazepines. Treatment should be in accordance with a treatment management plan, which should consider all available treatment options, including non-pharmacological strategies.

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SECTION F – DECLARATION

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

Where required, please select the option which applies:

☐ I confirm, where required, that I have sought a review and obtained written support from an appropriate medical specialist for the proposed treatment.

☐ I confirm I will seek specialist review and obtain written support from an appropriate medical specialist to support this application.

Signature: Print and Sign _____ Date: _____ (dd/mm/yyyy)