Application for Authority to Prescribe or Supply a Schedule 8 Medicine-Pain Management

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 supporting treatment
- **Sought a review and obtained a second opinion from a:**
  - **Pain specialist if:**
    - the patient is on OTP (and requires long term pain management)
  - **Pain or palliative medicine specialist if:**
    - applying for authority to prescribe or supply injectable opioids
  - **Pain, palliative, or rehabilitation medicine specialist if:**
    - oral Morphine Equivalent Daily Dose (oMEDD)is ≥100mg for an opioid drug
    - applying for authority to prescribe or supply a non-opioid S8 drug

Where possible the second opinion should be in writing from an appropriate medical specialist independent of the prescriber. Where multiple concerns exist one letter addressing all issues will be accepted.

Any application to prescribe or supply an injectable formulation or an oMEDD ≥100mg may require supporting documentation. Please allow additional processing time.

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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.**

The NSW Ministry of Health does not endorse self-administration of injectable opioids or administration by family members.

For Opioid prescribing recommendations in General Practice as published by ACI Pain Management Network, and for more information about the role of opioids in chronic non-cancer pain and further resources go to http://www.aci.health.nsw.gov.au

Oral Morphine Equivalent Daily Dose (oMEDD) is the opioid dosage as compared to oral morphine. To calculate the oMEDD go to Opioid dose equivalence calculation table or www.opioidcalculator.com.au

Please ensure all opioid medications currently used by the patient are included when calculating total oMEDD

For patients under 16 years, where treatment with a Schedule 8 drug will exceed 10 days in any period of 30 days a medical practitioner may request an exemption under the Children and Young Persons (Care and Protection) Act 1998, 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.

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: Drug Authorisation Details**
- ☐ **Yes. I am the authorised OTP prescriber.** Go to **Section D: Drug Authorisation Details**
- ☐ **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: Drug Authorisation Details**
  - ☐ **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 *ANY OF THE DRUGS LISTED BELOW* CONTINUOUSLY FOR MORE THAN TWO MONTHS?

An authority from the NSW Ministry of Health is required to prescribe or supply drugs of addiction to persons for continuous or ongoing treatment of more than two months for any of the following:

- any drug of addiction intended for administration by injection
- any drug of addiction for inhalation, or for spray or application to mucous membranes
- buprenorphine (except transdermal preparations)
- hydromorphone
- methadone

- ☐ **Yes. Authority required.** Go to **Section D: Drug Authorisation Details**
- ☐ **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 – DRUG AUTHORISATION DETAILS

If additional space is required, please use supplementary Drug Authorisation Details on last page.

Drug 1:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 2:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 3:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Total oMEDD: _____ Calculate total oMEDD if more than one opioid drug is used. For non-opioid drugs, Total oMEDD details are to be left blank.

IF YOU ARE A PAIN, PALLIATIVE OR REHABILITATION MEDICINE SPECIALIST GO TO 'INJECTABLE FORMULATIONS'

All other applicants please complete below

If the total opioid dose <100mg daily oMEDD: go to **'Injectable Formulations'**

If the total opioid dose ≥100mg daily oMEDD:

Any application to prescribe or supply an injectable formulation or an oMEDD ≥100mg may require supporting documentation. Please allow additional processing time.

Do you have written support for treatment at this **high dose** from a pain, palliative or rehabilitation medicine specialist preferably within a multidisciplinary pain clinic or service setting?

☐ **Yes**. Go to **'Injectable Formulations'**

☐ **No**. Refer the patient to a pain, palliative or rehabilitation medicine specialist and obtain written support for treatment at this high dose. Go to **'Injectable Formulations'**

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SECTION D – DRUG AUTHORISATION DETAILS (cont.)

INJECTABLE FORMULATIONS

Are you applying to prescribe or supply an injectable formulation?

- ☐ **No**. Go to '**Indications for Prescribing or Supply**'
- ☐ **Yes**. Are you a pain or palliative medicine specialist?
  - ☐ **Yes**. Go to '**Indications for Prescribing or Supply**'
  - ☐ **No**. Do you have written support from a pain or palliative medicine specialist for the use of an injectable formulation?
    - ☐ **Yes**. Go to '**Indications for Prescribing or Supply**'
    - ☐ **No**. Refer the patient to a pain or palliative medicine specialist and obtain written support. Go to '**Indications for Prescribing or Supply**'

INDICATIONS FOR PRESCRIBING OR SUPPLY

☐ **Palliative care**

What is the expected duration of treatment with the requested drug(s)? _____ months

Is this end of life care? ☐ **Yes** ☐ **No**

Are you a palliative medicine specialist?

- ☐ **Yes**. Go to **Section E: Declaration**
- ☐ **No**. Do you have written support for the proposed treatment from a palliative medicine specialist?
  - ☐ **Yes**. Go to **Section E: Declaration**
  - ☐ **No**. Refer the patient to a palliative medicine specialist and obtain written support. Go to **Section E: Declaration**

☐ **Cancer related pain** ☐ **Chronic non-cancer pain**

☐ **Other** _____ (please specify)

What is the expected duration of treatment with the requested drug(s)? _____ months

Are you a pain medicine or rehabilitation specialist?

- ☐ **Yes**. Go to **Section E: Declaration**
- ☐ **No**. Do you have written support for the proposed treatment from a pain medicine or rehabilitation specialist?
  - ☐ **Yes**. Go to **Section E: Declaration**
  - ☐ **No**. Refer the patient to a pain or rehabilitation medicine specialist and obtain written support. Go to **Section E: Declaration**

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SECTION D – SUPPLEMENTARY DRUG AUTHORISATION DETAILS

If required

Drug 4:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 5:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 6:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Total oMEDD: _____ Calculate total oMEDD if more than one opioid drug is used. For non-opioid drugs, Total oMEDD details are to be left blank.

SECTION E – 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 also tick 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)