NSW GOVERNMENT Health

Facility:

APPLICATION FOR AUTHORITY TO PRESCRIBE METHADONE OR BUPRENORPHINE UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

NSW HEALTH USE ONLY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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.

Section A: Patient Details

Patient Name:

(given name) *(middle name)* *(family name)*

Also known as:

(given name) *(middle name)* *(family name)*

Patient Residential Address:

Suburb/Town: **Postcode:**

Patient Date of Birth: **Sex:** ☐ Male ☐ Female

*If patient is aged 16 years to under 18 years, provide a second opinion from an approved prescriber. A report from this prescriber **must** be attached to this application.*

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

Section B: Application details

1. This application is for: ☐ Methadone ☐ Buprenorphine

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

☐ Currently on NSW OTP → *Go to Question 8*
☐ Not currently on NSW OTP but has previously been on NSW OTP
☐ Never has been on NSW OTP

3. 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

4. In which country was the patient born? ☐ Australia ☐ other, *specify:*

5. What is the patient's preferred language? ☐ English ☐ other, *specify:*

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

☐ heroin
☐ oxycodone
☐ codeine
☐ buprenorphine
☐ methadone
☐ morphine
☐ fentanyl
☐ hydromorphone
☐ pethidine
☐ other, *specify:*

7. What drug(s), other than opioids, does the patient perceive as being a concern? *(tick the appropriate box/es)*

☐ no other drugs of concern
☐ alcohol
☐ benzodiazepines
☐ cocaine
☐ cannabinoids
☐ ketamine
☐ MDMA *(e.g. ecstasy)*
☐ methamphetamine
☐ nicotine
☐ non opioid analgesic
☐ other, *specify:*

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

☐ Patient is not currently on the NSW OTP → *Go to Question 11*
☐ I (the applicant) am the current prescriber
☐ Justice Health
☐ Other NSW community prescriber, *specify full name:*
☐ Interstate or Overseas prescriber, *specify (e.g. Vic):*

Statement signed by the interstate prescriber showing the dose and date of last dose (including takeaways) is attached: ☐ Yes ☐ No

SMR130051

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

APPLICATION FOR AUTHORITY TO PRESCRIBE METHADONE OR BUPRENORPHINE UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP) SMR130.051

NH700459 080719

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Patient Name:

(given name) *(middle name)* *(family name)*

Section C: Dose information

9. 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.*

10. Last dose of methadone/buprenorphine dispensed: **mg**

11. Proposed starting date:

12. Proposed starting dose: **mg**

13. Expected maximum dose: **mg**

14. Has treatment been commenced as an inpatient immediately prior to this application: ☐ Yes ☐ No

15. Proposed administration (dosing) point:

Suburb/Town:

***Note**: Opioid Treatment line (OTL) 1800 642 428 can be contacted for registered dosing points in NSW*

Section D: Prescriber 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 issued by the 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 (see Privacy Statement below)**.**

Prescriber's Signature: Print & Sign **Date:**

Prescriber Name:

(given name) *(family name)*

Name of Practice:

Address:

Suburb/Town: **Postcode:**

Telephone: **Fax:** **Email:**

AHPRA Registration No: **PBS Prescriber No:**

HPI-I No *(if known)*:

Privacy Statement: The information set out in this form is required by the Ministry of Health 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 visit **http://www.health.nsw.gov.au/patients/privacy**. For further advice or clarification please email **MOH-OTP@health.nsw.gov.au**

Fax completed form and supporting documentation to the Pharmaceutical Regulatory Unit: 02 9424 5885
For enquiries: Tel 02 9424 5921 during business hours.

NO WRITING