Clear Form

BD10/19

Application for Authority to Prescribe a Schedule 8 Drug – Alprazolam or Flunitrazepam

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 7 business days.

Section A: Prescriber details

Prescriber Name:

(first names) *(family name)*

Name of Practice:

Address:

Suburb/Town: **Postcode:**

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

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

AHPRA Specialty/Field: ☐ Psychiatry ☐ Respiratory & Sleep Medicine ☐ General Practice

☐ Other specialty, *please specify* .....

Section B: Patient details

Patient Name:

(first names) *(family name)*

Also known as *(if applicable)*:

(first names) *(family name)*

Patient Residential Address:

Suburb/Town: **Postcode:**

Patient Date of Birth: __ __ __ __ __ __ __ __ **Sex:** ☐ M ☐ F

Is the patient aged over 70 years?

☐ N

☐ Y ····▶ *Elderly or debilitated patients are more susceptible to adverse effects which may increase risk of falls. Dosage should be the smallest effective amount in such patients*

Do you consider this patient to be drug dependent? ☐ Y ☐ N

A 'drug dependent person' means a person who has acquired, as a result of repeated administration of a drug of addiction or 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).

Do you have any of the following concerns?

☐ past/current IV drug use ☐ drug seeking ☐ unsanctioned dosage escalation
☐ illicit drug use ☐ doctor shopping ☐ medical dependence
☐ diversion ☐ drug misuse ☐ lost prescriptions/medication
☐ longer period of use than intended or appropriate

☐ no concerns

Is the patient currently enrolled on the Opioid Treatment Program (OTP)?

☐ N

☐ Y ····▶ *A letter from the authorised OTP prescriber supporting benzodiazepine treatment must be attached. A second opinion from a psychiatrist or Addiction Medicine specialist may be requested*

Diagnosis:

☐ Panic disorder ☐ Generalised anxiety disorder ☐ Severe insomnia

☐ Other, *please specify* .....

Note: A second opinion may be requested in some circumstances, e.g. where flunitrazepam is being requested to treat a diagnosis other than severe insomnia

Section C: Benzodiazepine drug authorisation details

Drug: ☐ Alprazolam ☐ Flunitrazepam

Maximum Daily Dose: ..... mg

If unable to specify a maximum daily dose, indicate the dosage and frequency:

.....

Note: If dosage P.R.N. indicate maximum per week/month

For alprazolam ····▶ *Continue (Section D)* ***For flunitrazepam*** ····▶ *Go to Section E*

Section D: Alprazolam

Prior to initiation or re-initiation of alprazolam, it is expected that the patient will have been reviewed by a psychiatrist

If you are a psychiatrist ····▶ *Go to Q4*

1. Is the patient currently being prescribed alprazolam?

☐ Y

☐ N

2. Indicate below the circumstances of your application and provide specialist review dates as applicable

☐ The patient was reviewed by a psychiatrist on *(please specify)* __ __ __ __ _ _ _ _ ····▶ *A recent letter or report from the psychiatrist supporting alprazolam treatment must be attached. Note: A report older than 12 months is not considered to be recent.*

☐ The patient will be reviewed by a psychiatrist on *(please specify)* __ __ __ __ _ _ _ _

☐ A review by a psychiatrist has not been planned *Please specify why you are applying to prescribe for this patient*

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····▶ ***Go to Q4***

Section E: Flunitrazepam

3. If you are a psychiatrist or respiratory and sleep medicine specialist ····▶ *Go to Q4*

If you are not a psychiatrist or respiratory and sleep medicine specialist:

Indicate below the circumstances of your application and provide specialist review dates as applicable (tick one box only):

☐ The patient was reviewed by an appropriate specialist in the last 12 months,
on *(please specify)* __ __ __ __ __ __ __ ····▶ *A report from the specialist must be attached*

☐ The patient will be reviewed by *(please specify name and address of specialist)* .....

.....

on *(please specify)* __ __ __ __ __ __ __ __

☐ Other, *please specify why you are applying to prescribe for this patient*

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Section F: Management

4. What other treatments have been trialled?

☐ None

☐ Cognitive behaviour therapy (CBT) ☐ Relaxation techniques

☐ Stimulus control ☐ Sleep hygiene

☐ Other non-pharmacotherapy, *please specify* .....

☐ Selective serotonin reuptake inhibitor (SSRI)

☐ Serotonin noradrenaline [norepinephrine] reuptake inhibitor (SNRI)

☐ Other medications, *please specify* .....

5. What is your management plan for the patient?

☐ Reducing dose to cease *Please specify expected date of cessation* __ __ __ __ __ __ __ __

☐ Continuation *Please describe the ongoing management plan for the patient, including reasons for continuing treatment and the use of the medication in the overall treatment plan, and the duration of treatment*

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Section G: Declaration

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

Signed: ..... Date: __ __ __ __ __ __ __ __

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.

Fax completed form and supporting documentation to the Pharmaceutical Regulatory Unit: 02 9424 5889
Enquiries: Tel 02 9424 5923 or email MOH-S8Auth@health.nsw.gov.au
Allow up to 7 business days for the processing of applications.