NSW GOVERNMENT

PN10/19

Application for Authority to Prescribe a Schedule 8 Drug – Pain Management

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: ☐ General Practice ☐ Pain Medicine ☐ Addiction Medicine ☐ Palliative Medicine

☐ 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

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

Section C: Drug authorisation details

oral Morphine Equivalent Daily Dose (oMEDD) is the opioid dosage as compared to oral morphine.
Opioid prescribing recommendations in general practice (published by ACI Pain Management Network) are as follows:

- *≤40mg daily oMEDD for non-cancer pain for a maximum 90 days*
- *≤300mg daily oMEDD for cancer pain*

For opioid doses ≥100mg daily oMEDD, a specialist review is recommended.
To calculate the oMEDD go to http://fpm.anzca.edu.au/documents/opioid-dose-equivalence or http://www.opioidcalculator.com.au/
More information about the role of opioids in chronic non-cancer pain and further resources go to http://www.aci.health.nsw.gov.au/chronic-pain
Note: For non-opioid drugs, 'Total oMEDD' details are to be left blank.

Drug (1): .... **Form:** .... **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*	Total oMEDD
Drug (2): .... **Form:** .... **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*	Total oMEDD
Drug (3) : .... **Form:** .... **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*	Total oMEDD

Section D: Diagnostic criteria and other management information

1. Diagnosis

- ☐ Cancer
- ☐ Other, *please specify* .... → *Go to Q3*

2. Prognosis: What is the prognosis for this patient? .... (months)

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

- ☐ No, the patient is NOT currently on the OTP → *Go to Q5*
- ☐ Yes, the patient is currently on the OTP and I am the authorised OTP prescriber

  Note: If you are not the authorised OTP prescriber, you must contact the authorised OTP prescriber and obtain a letter of support
- ☐ Yes, the patient is currently on the OTP and I have a letter of support from the authorised OTP prescriber

  → *The letter of support must be attached*

4. Is there a report from an addiction medicine specialist supporting concurrent OTP treatment?

- ☐ Y → *The report must be attached*
- ☐ N → *A report from an addiction medicine specialist may be requested*

5. If you are a palliative medicine or pain medicine specialist → *Go to Q6*

If you are not a palliative medicine or pain medicine specialist:

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

☐ I have a recent report from a palliative medicine or pain medicine specialist → *The report must be attached.*

Note: A report older than 12 months is not considered to be recent

☐ 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*

....

....

Section E: Injectable opioids

6. Are you applying to prescribe an injectable opioid?

☐ N → *Go to Q9*

☐ Y → *A report from a pain medicine or palliative medicine specialist supporting the drug and dose must be attached*

7. How often will injections be administered? ....

Note: If frequency P.R.N. indicate the average per day/week/month

8. Who will administer the injections?

Note: The Ministry does not endorse self-administration or administration by family members

☐ I as the prescriber ☐ Other medical practitioner ☐ Nurse

☐ Other, *please specify* ....

→ ***Go to Q10***

Section F: Pain Management details

9. Are you applying to prescribe a total oMEDD > 400mg?

☐ N → *Go to Q12*

☐ Y

10. What analgesic medications is the patient currently taking (including opioids and non-opioids)?

Drug	Dose	Frequency	Rate effectiveness *(1 = low, 5 = high)*

11. What other medications have been trialled?

Drug	Route of administration	Brand name	Rate effectiveness *(1 = low, 5 = high)*	Reasons for discontinuing *e.g. ineffective, allergy, adverse effects such as vomiting*

12. What other non-pharmacological pain relief treatments have been trialled?

☐ None

☐ Cognitive behaviour therapy (CBT) ☐ Relaxation techniques ☐ Counselling

☐ Physiotherapy ☐ Hydrotherapy ☐ Massage therapy

☐ Exercise therapy ☐ Acupuncture

☐ Other, *please specify* ....

13. Is there a written management plan for the patient?

☐ Y

☐ N

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

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.