NSW Health

Application for Authority to Prescribe or Supply a Schedule 8 Drug – Psychostimulant for Attention Deficit Hyperactivity Disorder (ADHD)

as required under the *NSW Poisons and Therapeutic Goods Act 1966*

This form is to be used to apply for an authority to prescribe or supply a psychostimulant (dexamfetamine, lisdexamfetamine or methylphenidate) for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in a child or adult.

Are you a:

General Practitioner – applications for initiation of psychostimulant therapy will generally not be approved.

General Practitioners applying for authority under shared care arrangements or continuing care must obtain written approval from the patient's treating specialist supporting shared care or the transfer of prescribing. This support should include the reason for transfer and confirm the current drug and dose. Treatment with the current specialist is generally expected to have been in place for a minimum of 6 months. Please refer to 'Before Starting the Application' checklist

Other Designated Prescriber (ODP) – applications where prescribing is not within routine prescribing criteria (see NSW Ministry of Health Guidelines for ADHD, link below) will not be approved. Please refer to 'Before Starting the Application' checklist

Paediatrician, Child & Adolescent Psychiatrist, Psychiatrist, or a Neurologist – with a **General Authority Number** to prescribe psychostimulant medication for the treatment of ADHD without prior authority. If prescribing meets all **routine prescribing criteria**, YOU DO NOT need to apply for individual patient approval and can use your General Authority Number. If prescribing is not within routine prescribing criteria, please complete this application.

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

- Ensured the patient meets the criteria for Hyperkinetic Disorder (ICD-11) and/or **Attention Deficit Hyperactivity Disorder (DSM-5)**. If not, use Application for Authority to Prescribe or Supply a Schedule 8 Psychostimulant, Other than for ADHD, for Children and Adults
- **Considered the patient's age.** An authority will not be granted to prescribe to a child aged less than 2 years of age
- **Contacted the authorised Opioid Treatment Program prescriber** if the patient is currently enrolled in the Opioid Treatment Program (OTP) and have a letter from the OTP prescriber supporting psychostimulant treatment
- **Sought a review and obtained a second opinion** for all high dose applications

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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.

The NSW Ministry of Health recommends prescribing is in accordance with the approved Product Information (PI), published recommendations and NSW Ministry of Health Regulatory Guidelines.

- **TG181** Criteria for the Management of Medication for Attention Deficit Hyperactivity Disorder in Children and Adolescents
- **TG190** Criteria for the Management of Medication for Attention Deficit Hyperactivity Disorder in Adults
- 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 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. 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. 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 the above checklist, the information contained in 'Clinical Advice and Support' and the 'Privacy Statement'**

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

Submitting the application:

Fax completed form and supporting documentation, if required, to the Pharmaceutical Regulatory Unit:
Fax: **(02) 9424 5889**
email: MOH-S8Auth@health.nsw.gov.au

Processing Time:

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

Please note: Please allow additional application processing time if your application is related to authority to prescribe or supply a psychostimulant in children under 4 years of age (dexamfetamine or methylphenidate) or 6 years of age (lisdexamfetamine) and/or in high dose for a child or adolescent. Contact the Pharmaceutical Regulatory Unit for any additional information and to check on the progress of your application.

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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: _____ Ref no.: _____

DVA Number: _____

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

Patient height: _____ cm Weight: _____ kg on _____ (*dd/mm/yyyy*)

(not required for patients aged over 18 years)

Blood Pressure: _____ mmHG

(required for high dose applications in patients aged under 18 years)

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SECTION C – Pre-Questions:

If applying for a child under 12 years of age, proceed to Section D: Drug Authorisation Details

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**. Go to question 2

☐ **No**. Go to **Section D: Drug Authorisation Details**

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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.

SECTION D – DRUG AUTHORISATION DETAILS

DRUG, PLEASE TICK ALL APPLICABLE BOXES.

☐ Dexamfetamine	Maximum daily dose: _____	mg
☐ Methylphenidate	Maximum daily dose: _____	mg
☐ Lisdexamfetamine	Maximum daily dose: _____	mg

If multiple drugs have been selected, confirm the reason:

☐ **For the purpose of a patient trial. These drugs are to be used individually (that is one at time) on a trial basis**

☐ **For combination therapy. That is the selected drugs are to be used at the same time**

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SECTION E – PATIENT AGE AND DOSE

E1. Patients aged 2 to 3 years (dexamfetamine and methylphenidate)
Patients aged 2 to 5 years (lisdexamfetamine)

Supporting documentation will be required. Please allow additional processing time.

☐ Are you initiating psychostimulant therapy?

- ☐ **Yes**. Proceed to Treatment Initiation
- ☐ **No**. Please confirm:
  - ☐ **Yes**. I have attached a patient progress report and a progress report from a specialist providing a second opinion. Please proceed to **Section F: Declaration**
  - ☐ **No**, I have not attached the required progress reports. **This application cannot proceed** until supporting documentation is provided

Treatment Initiation

Are you a paediatrician or child & adolescent psychiatrist?

- ☐ **No**. **This application cannot procced**. Please refer patient to a paediatrician or child & adolescent psychiatrist
- ☐ **Yes**, please confirm:
  - ☐ I have attached a second supporting opinion from an independent specialist and have attached a detailed clinical report including:
    1. Description of the behaviour in at least two settings, as described by day care providers, allied health therapists, parents, or schoolteachers.
    2. Assessment of functional impairment, for example ability to meet age-appropriate behavioural expectations, quality of peer or sibling interactions and achievement in relation to ability.
    3. Response to non-pharmacological intervention. Proceed to **Section F: Declaration**
  - ☐ **No**, I have not attached a second supporting opinion or a detailed clinical report. **This application cannot proceed**. Please refer patient for a second opinion and provide a detailed clinical report

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SECTION E – PATIENT AGE AND DOSE (cont.)

E2. Patients aged 4 to 17 years (dexamfetamine and methylphenidate)
Patients aged 6 to 17 years (lisdexamfetamine)

Are you a paediatrician, child & adolescent psychiatrist, ODP or a psychiatrist (adult) or neurologist intending to prescribe for a 16-17 year old (inclusive)?

☐ **Yes**. Go to question A

☐ **No**. Do you have written support from a paediatrician or a child & adolescent psychiatrist supporting a shared care arrangement?

- ☐ **Yes**. Go to question A
- ☐ **No**. Refer the patient to a paediatrician or a child and adolescent psychiatrist and obtain written support. Go to question A

A. Does the daily dose exceed any of the following and/or is combination therapy to be used?

- 1mg/kg/day for dexamfetamine, up to a maximum of 50mg per day
- 2mg/kg daily for methylphenidate, up to a maximum of 108mg daily
- a maximum of 70mg lisdexamfetamine per day

☐ **No**. Go to **Section F: Declaration**

☐ **Yes**. High dose applications will only be considered from paediatricians or child & adolescent psychiatrists. Supporting documentation, including a current clinical summary, growth charts and reports from relevant observers will be requested. Please allow additional processing time. Go to **Section F: Declaration**

E3. Patients aged 18 to 64 years

Are you a psychiatrist, a paediatrician (continuing care for patients up to the age of 25 years) or a neurologist (continuing care for patients aged older than 18 years)?

☐ **Yes**. Go to question A

☐ **No**. Do you have written support from a psychiatrist, or a neurologist supporting shared care or the transfer of prescribing?

- ☐ **Yes**. Go to question A
- ☐ **No**. Refer the patient to a psychiatrist, or a neurologist and obtain written support for shared care or the transfer of prescribing. Go to question A

A. Does the daily dose exceed any of the following and/or is combination therapy to be used?

- 30mg for dexamfetamine
- 60mg for methylphenidate IR or 80mg for methylphenidate CR
- 70mg for lisdexamfetamine

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SECTION E – PATIENT AGE AND DOSE (cont.)

E3. Patients aged 18 to 64 years (cont.)

- ☐ **No**. Go to **Section F: Declaration**
- ☐ **Yes**. Has the patient been reviewed by a second, independent psychiatrist and do you have written support for treatment at a high dose and/or for use of combination therapy?
  - ☐ **Yes**. Go to **Section F: Declaration**
  - ☐ **No**. Refer the patient to a psychiatrist and obtain written support for treatment at a high dose and/or for combination therapy. Go to **Section F: Declaration**

E4. Patients aged 65 years and over

Has the patient previously been treated with psychostimulant medication?

- ☐ **No**. Are you a psychiatrist initiating treatment?
  - ☐ **Yes**. Go to question A
  - ☐ **No**. Do you have written support from a psychiatrist for the initiation of psychostimulant treatment?
    - ☐ **Yes**. Go to question A
    - ☐ **No**. Refer the patient to a psychiatrist and obtain written support for the initiation of psychostimulant treatment. Go to question A
- ☐ **Yes**. Are you a psychiatrist?
  - ☐ **Yes**. Go to question A
  - ☐ **No**. Do you have written support from a psychiatrist supporting shared care or the transfer of prescribing?
    - ☐ **Yes**. Go to question A
    - ☐ **No**. Refer the patient to a psychiatrist and obtain written support for shared care or the transfer of prescribing. Go to question A

A. Does the daily dose exceed any of the following and/or is combination therapy to be used?

- 30mg for dexamfetamine
- 60mg for methylphenidate IR or 80mg for methylphenidate CR
- 70mg for lisdexamfetamine

- ☐ **No**. Go to **Section F: Declaration**
- ☐ **Yes**. Has the patient been reviewed by a second, independent psychiatrist and do you have written support for treatment at a high dose and/or for use of combination therapy?
  - ☐ **Yes**. Go to **Section F: Declaration**
  - ☐ **No**. Refer the patient to a psychiatrist and obtain written support for treatment at a high dose and/or for combination therapy. Go to **Section F: Declaration**

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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 and

if required, please 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*)

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