NSW Health

Application for Authority to Prescribe Certain Restricted Substances

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

This form is for the purpose of applying for an authority to prescribe certain restricted substances listed in clause 37 of the *Poisons and Therapeutic Goods Regulation 2008*

Before starting the application:

Please check the table below. The specialities listed below are 'authorised' to prescribe the corresponding substances. If you are one of these specialists, **YOU DO NOT NEED TO APPLY FOR AUTHORITY** to prescribe the relevant substances. Practitioners must clearly indicate on the prescription the words: **'Issued under clause 37 of the Poisons and Therapeutic Goods Regulation 2008'** or words to that effect.

All other practitioners are required to apply for an authority and obtain supporting documentation from the patient's current prescriber, a specialist (who is authorised to prescribe).

SPECIALITY		YOU ARE AUTHORISED TO PRESCRIBE
• Dermatology (FACD)		acitretin, etretinate, isotretinoin for oral use
• Obstetrics & Gynaecology (FRCOG, FRANZCOG)		clomiphene, cyclofenil, dinoprost, dinoprostone
• Obstetrics & Gynaecology (FRCOG, FRANZCOG) • Physician (FRACP) (practising endocrinology in a Specialist Endocrinology Unit)		clomiphene, cyclofenil
• Endocrinology (FRACP)		follitropin beta, luteinising hormone, urofollitropin (human FSH)
• Haematology (FRACP)		tretinoin for oral use
• Adult & Paediatric Infectious disease physicians • Dermatology (FACD) • Adult & Paediatric Gastroenterology, • Adult & Paediatric Hepatology	• A medical or nurse practitioner practising in a public hospital to treat patients of the hospital • A medical practitioner or nurse practitioner prescribing or supplying topical preparations	ivermectin for a non-TGA approved indication
• Dermatology • Intensive Care Medicine • Paediatrics & Child Health • Emergency Medicine • Physician	• A medical practitioner practicing in a public hospital to treat patients of the hospital • A dentist registered in the specialty of oral medicine	hydroxychloroquine

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Clinical Advice and Support:

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

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 table, the information contained in 'Clinical Advice and Support' and the 'Privacy Statement'**

Enquiries

Please direct any enquiries to the Pharmaceutical Regulatory Unit: Tel: **(02) 9391 9944**
email: MOH-PharmaceuticalServices@health.nsw.gov.au

Submitting the application:

Fax completed form to the Pharmaceutical Regulatory Unit: Fax: **(02) 9424 5860**
email: MOH-PharmaceuticalServices@health.nsw.gov.au

Processing Time:

Please allow up to **10 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: _____ Ref no.: _____

DVA Number: _____

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

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SECTION C – DRUG AUTHORISATION DETAILS

DRUG

- ☐ acitretin
- ☐ clomiphene
- ☐ cyclofenil
- ☐ dinoprost
- ☐ dinoprostone
- ☐ etretinate
- ☐ follitropin beta
- ☐ hydroxychloroquine
- ☐ isotretinoin for oral use
- ☐ ivermectin
- ☐ luteinising hormone
- ☐ tretinoin for oral use
- ☐ urofollitropin (human follicle stimulating hormone)

Do you have written agreement from the *'authorised'* specialist who is currently treating and prescribing for this patient?

☐ **Yes**. Go to **Section D: Declaration**

☐ **No**. Contact the *'authorised'* specialist and obtain written agreement before submitting this application. This application **cannot proceed** and will not be considered until written agreement is obtained.

☐ I am NOT an *'authorised'* specialist and I want to prescribe a substance listed in clause 37, within my scope of practice. I have informed the patient of the risks associated with prescribing this substance outside that which is outlined in the approved product information. Go to **Section D: Declaration**

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 that prescribing is within my scope of practice**

Signature: _____ Print and Sign Date: _____ (*dd/mm/yyyy*)

SHPN (LRS) 221034