

Application for Authority to Prescribe a Psychostimulant for Attention Deficit Hyperactivity Disorder (ADHD) in a Child or Adolescent

This form is for use by paediatricians, child psychiatrists and psychiatrists, and other designated prescribers to apply for an individual patient authority to prescribe dexamfetamine, lisdexamfetamine or methylphenidate for the treatment of ADHD in a person aged less than 18 years. Prescribing is to be in accordance with TG181 'Criteria for the Diagnosis and Management of ADHD in Children and Adolescents'.

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:		
<i>(first names)</i>	<i>(family name)</i>	
Name of Practice:		
Address:		
Suburb/Town:		Postcode:
Telephone:	Fax:	Email:
AHPRA Registration No:		PBS Prescriber No:
Prescriber category: <input type="checkbox"/> Paediatrician <input type="checkbox"/> Child psychiatrist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other designated prescriber <input type="checkbox"/> General Practitioner <input type="checkbox"/> Other, please specify		
Section B: Patient details		
Patient Name:		
<i>(first names)</i>	<i>(family name)</i>	
Also known as (if applicable):		
<i>(first names)</i>	<i>(family name)</i>	
Patient Residential Address:		
Suburb/Town:		Postcode:
Patient Date of Birth: ____ ____ ____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Patient Height: cm	Weight: kg	Date height/weight measured: ____ ____ ____
Section C: Psychostimulant drug authorisation details		
Drug: <input type="checkbox"/> Dexamfetamine <input type="checkbox"/> Methylphenidate <input type="checkbox"/> Lisdexamfetamine		
Dose: mg per day in doses at mg/kg/day		
<i>Note: An 'Application for Authority to Prescribe a Psychostimulant in a High Dose for the Treatment of ADHD in a Child or Adolescent' must be submitted for doses exceeding:</i> <ul style="list-style-type: none"> • 1mg/kg daily or 50mg daily of dexamfetamine • 2mg/kg daily or 108mg daily of methylphenidate • 70mg daily of lisdexamfetamine 		

Section D: Diagnostic criteria and other management information	
1. Diagnosis: <input type="checkbox"/> Hyperkinetic Disorder (ICD-10)	<input type="checkbox"/> Attention Deficit Hyperactivity Disorder (DSM-5)
2. Symptoms: This patient exhibits developmentally inappropriate:	
<input type="checkbox"/> Inattention	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Hyperactivity	
3. Have psychostimulants been previously prescribed for the patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
4. In the past 6 months, has the patient been off medication for a period of time to assess whether the continuation of medication is necessary?	
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Not applicable (patient recently started or has not started medication)	
5. What other management approaches have been used or are being used?	
<input type="checkbox"/> Remedial teaching <input type="checkbox"/> Behaviour modification/therapy <input type="checkbox"/> Family/individual counselling	
<input type="checkbox"/> Other, <i>please specify</i>	
Section E: Outside routine prescribing criteria (See TG181) - For paediatricians and child psychiatrists only	
<i>For other applicants</i>▶ Go to Section F	
Where indicated below, a <u>detailed clinical report</u> is to be attached, and <u>must</u> include the following:	
<ul style="list-style-type: none"> • Description of the behaviour in at least 2 settings, as described by day care providers, allied health therapists, parents, or school teachers. • 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. • Response to non-pharmacological interventions. 	
Any additional reports requested by the Stimulants Subcommittee are to be attached.	
<i>Note: Authority <u>will not</u> be granted to prescribe for children aged less than 2 years.</i>	
6. Is the child aged <u>2 years</u>?	
<input type="checkbox"/> N	
<input type="checkbox"/> Y →	<div style="display: flex; align-items: center;"> <div style="border-left: 1px dashed black; border-right: 1px dashed black; padding: 0 10px;"> <p>A detailed clinical report as described above is attached <input type="checkbox"/> Y</p> <p>A specialist report providing a <i>second opinion</i> is attached <input type="checkbox"/> Y</p> </div> <div style="margin-left: 20px;">} → Go to Q8</div> </div>
7. Is the child aged <u>3 years</u>?	
<input type="checkbox"/> N	
<input type="checkbox"/> Y →	<div style="display: flex; align-items: center;"> <div style="border-left: 1px dashed black; border-right: 1px dashed black; padding: 0 10px;"> <p>A detailed clinical report as described above is attached <input type="checkbox"/> Y</p> <p>A report from <i>relevant observer other than parent</i> is attached <input type="checkbox"/> Y</p> </div> </div>
8. Do you have concerns about possible <u>contraindications</u> (e.g. psychiatric comorbidity)?	
<input type="checkbox"/> N	
<input type="checkbox"/> Y →	<div style="display: flex; align-items: center;"> <div style="border-left: 1px dashed black; border-right: 1px dashed black; padding: 0 10px;"> <p><i>Please specify</i></p> </div> </div> <p>A detailed clinical report as described above is attached <input type="checkbox"/> Y</p>
9. Do you have concerns about <u>adverse effects</u> - mood (e.g. anxiety, depression, paranoia), reduced appetite, slowing growth velocity, tics/Tourette's Disorder?	
<input type="checkbox"/> N	
<input type="checkbox"/> Y →	<div style="display: flex; align-items: center;"> <div style="border-left: 1px dashed black; border-right: 1px dashed black; padding: 0 10px;"> <p><i>Please specify</i></p> </div> </div> <p>A detailed clinical report as described above is attached <input type="checkbox"/> Y</p>

Section F: Declaration

10. If you are a specialist▶ *Go to Q13*

If you are not a specialist:

11. Have you confirmed with the treating specialist that he or she is not able to prescribe psychostimulant medication for the patient at this time?

Y N

12. Indicate below the circumstances of your application (*tick one box only*):

I am applying to prescribe on an interim basis until the specialist can continue prescribing. A report from the specialist is attached, indicating the patient's current drug and dose, and duration of treatment.

Other, *please specify why you are applying to prescribe psychostimulants for this patient (include any referral dates)*

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13. 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.