Clear Form

HD10/19

Application for Authority to Prescribe a Psychostimulant in a High Dose for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in a Child or Adolescent

This form is to be completed to obtain authorisation to prescribe a psychostimulant for a child or adolescent for a dose exceeding:

- 1mg/kg daily or 50mg daily of dexamfetamine
- 2mg/kg daily or 108mg daily of methylphenidate
- 70mg daily of lisdexamfetamine

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: ☐ Paediatrics ☐ Psychiatry ☐ 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

Patient Height: ..... cm **Weight:** ..... kg on __ __ __ __ __ __ __ __ *(date)*	**Blood Pressure:** / mmHg

Section C: Psychostimulant drug authorisation details

Drug: ☐ Dexamfetamine ☐ Methylphenidate ☐ Lisdexamfetamine

Total Daily Dose: ..... mg

Section D: Dose response and treatment details

Indicate below the patient's response to the highest dose prescribed within routine criteria and the requested dose outside criteria on the characteristics listed:

Scale: **1** = no improvement **2** = some improvement **3** = marked improvement **4** = very marked improvement

Note: Refer to TG181 'Criteria for the Diagnosis and Management of ADHD in Children and Adolescents' for details on the routine prescribing criteria

	Highest Dose within Criteria	Requested Dose (Outside Criteria)
Attention		
Concentration		
Behaviour		
Social		

Has the patient experienced side effects on the requested dose (outside criteria)?

☐ N

☐ Y, *please list below the side effects experienced and indicate their severity*

Side effect ..... ☐ mild ☐ significant

Side effect ..... ☐ mild ☐ significant

Side effect ..... ☐ mild ☐ significant

Indicate what other medication(s) have been tried previously to treat the patient's ADHD symptoms:

☐ None ☐ Clonidine ☐ Anticonvulsant ☐ Atypical antipsychotic

☐ Selective serotonin reuptake inhibitor (SSRI)

☐ Other, *specify* .....

Are any psychotropic drugs being used concurrently with psychostimulant medication?

☐ Y, *please specify* .....

☐ N

Section E: Supporting documentation

The following documentation to support this application must be attached:

☐ Current clinical summary including the reasons for not using the alternate psychostimulant medication within the criteria (e.g. if applying for methylphenidate, provide reasons for not using a dose of dexamfetamine of ≤1mg/kg/day).

☐ Growth charts (or height/weight percentiles) for the period from or before the commencement of psychostimulant treatment to the present. CDC Growth Charts are preferred.

☐ Reports from relevant observers (e.g. parents, teachers) documenting advantages of using a dose outside the criteria.

Section F: 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.