Application for Temporary Interstate Transfer to NSW Opioid Treatment Program

This form is to be used for short term transfers. For other transfers, complete Application for Authority to Prescribe or Supply Methadone, Buprenorphine or other Opioid Agonist Therapy (OAT) Treatment Under the NSW Opioid Treatment Program (OTP)

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

- **Contacted the Opioid Treatment line (OTL) 1800 642 428** for details of registered dosing points in NSW
- **Confirmed availability and placement** at the chosen dosing point, for a temporary interstate transfer

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.

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 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 or supply a Schedule 8 medicine 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. Practitioner information, and data regarding the number of patients for whom they hold authorities to prescribe or supply a Schedule 8 medicine, may also be used and disclosed for policy and planning purposes. 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 am the authorised opioid pharmacotherapy prescriber in my home state/territory**

☐ **I confirm that I have read and understood all the information above including 'Clinical Advice and Support' and the 'Privacy Statement'**

(These declarations are mandatory and must be completed)

Submitting the application:

Fax completed form to the Pharmaceutical Regulatory Unit: Fax: **(02) 9424 5885**
or email to: MOH-OTP@health.nsw.gov.au

Enquiries:

Please direct any enquiries to the Pharmaceutical Regulatory Unit: Tel: **(02) 9424 5921**
email: MOH-OTP@health.nsw.gov.au

Processing Time:

Please allow up to **2 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): (if applicable) _____

Family Name: _____

Address: _____ Suburb/town: _____

Postcode: _____ Medicare number: (if applicable) _____ Ref no.: _____

DVA number: (if applicable) _____

DOB: _____ (dd/mm/yyyy) Sex: ☐ Male ☐ Female ☐ Another term ☐ Not stated

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SECTION C – TRANSFER DETAILS

Has the patient previously been enrolled on the NSW Opioid Treatment Program? ☐ **Yes** ☐ **No**

Current dose:

☐ Methadone: _____ mg **OR** ☐ Buprenorphine: _____ mg

Date of last dose *(including any takeaway doses)*: _____ *(dd/mm/yyyy)*
Note: This is the last dose administered prior to transfer to NSW

Proposed starting date for treatment in NSW: _____ *(dd/mm/yyyy)*

Proposed end date for treatment in NSW *(including any takeaway doses)*: _____ *(dd/mm/yyyy)*

Name of proposed dosing point in NSW: _____

Suburb/Town: _____

Proposed starting dose in NSW:

☐ Methadone: _____ mg ☐ Buprenorphine: _____ mg

Note: A valid prescription must be forwarded directly to the clinic or pharmacy where dosing will take place. Do not send the prescription with the patient.

SECTION D – DECLARATION

☐ **I confirm that the information I have provided in this application is true and complete to the best of my knowledge.**

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