NSW Health

Application for Authority to Prescribe Certain Restricted Substances

as required under the Poisons and Therapeutic Goods Regulation 2008 (NSW)

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).

AUTHORISED CLASS OF PERSONS		YOU ARE AUTHORISED TO PRESCRIBE
• Medical practitioners registered in the specialty of dermatology		acitretin, etretinate, isotretinoin for oral use
• Medical practitioners registered in the specialty of obstetrics & gynaecology • Medical practitioners registered in the speciality field of endocrinology		clomifene, cyclofenil, follitropin beta, luteinising hormone, urofollitropin (human FSH)
• Medical practitioners registered in the specialty of obstetrics & gynaecology		dinoprost, dinoprostone
• Medical practitioners registered in the specialty of dermatology • Medical practitioners registered in the speciality field of haematology		tretinoin for oral use
Medical practitioners registered in the specialty or specialty field of: • Dermatology • Emergency Medicine • Intensive Care Medicine • Paediatrics and Child Health • Physician	• A medical practitioner practicing in a public hospital to treat patients of the hospital • A dentist registered in the specialty of oral medicine (for authorised conditions)	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 or supply restricted substances 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 restricted substances, 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 have read and understood the above table, the information contained in 'Clinical Advice and Support' and the 'Privacy Statement'**

(This declaration is mandatory and must be completed)

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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NSW GOVERNMENT

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 (if applicable): _____ Ref no.: _____

DVA number (if applicable): _____

DOB: _____ (dd/mm/yyyy)

Sex: ☐ Male ☐ Female ☐ Another term

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SECTION C – DRUG AUTHORISATION DETAILS

DRUG

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

Where there is an authorised specialist currently prescribing for the patient, do you have written agreement from the authorised specialist? (Please tick the option which applies)

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

or

☐ **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.

or

☐ 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 D – DECLARATION

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

Where required, please also tick the option which applies:

☐ **I confirm, where required, that I have sought a review and obtained written agreement from the authorised specialist for the proposed treatment.**

☐ **I confirm that prescribing is within my scope of practice.**

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