Application for Authority to Prescribe or Supply Methadone (>200mg/day) or Buprenorphine (>32mg/day) under the NSW Opioid Treatment Program (OTP)

as required under the Poisons and Therapeutic Goods Act 1966 (NSW)

Applications to prescribe or supply methadone or buprenorphine under the NSW Opioid Treatment Program (OTP) are to be made using 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 MOH-OTP-Accred@health.nsw.gov.au for a list of approved prescribers for a second opinion

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.

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

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

(This declaration is mandatory and must be completed)

Submitting the application:

Email the completed form and supporting documentation to MOH-OTP-Accred@health.nsw.gov.au

Enquiries:

Please direct any enquiries to MOH-OTP-Accred@health.nsw.gov.au

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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: (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 – DRUG AUTHORISATION DETAILS

☐ **Methadone**

Current dose: _____ mg Maximum dose applied for: _____ mg

☐ **Buprenorphine**

Route of administration: _____

Current dose: _____ mg Maximum dose applied for: _____ mg

Current dosing point: (please specify) _____

Reason for increased dose:

☐ Patient experiencing withdrawal at current dose

☐ Other: (please specify) _____

SECTION D – ATTACHMENTS

Yes, I have attached the following documents:

☐ A letter containing the following clinical details:

- a comprehensive list of the patient's current medicines including dosage from all practitioners (if known)
- a history of dose escalation on requested treatment and length of time patient has remained on the maximum dose
- a record of all doses for the last month
- any alternative strategies attempted such as split dosing to achieve stability
- full set of general observations 4 hours post dose with Clinical Opiate Withdrawal Scale (COWS) or Objective Opioid Withdrawal Scale (OOWS). *Note: please ensure that a supervised dose was administered on the day of assessment and that regular dosing has been occurring*
- number of takeaway or unsupervised doses per week
- relevant details of medical, psychiatric, and psychosocial circumstances e.g., chronic pain, psychiatric disorder, including supportive documentation from other specialists

☐ A supporting second opinion obtained (including information on method of obtainment e.g., via telehealth consultation) from a prescriber who is a Fellow of the Chapter of Addiction Medicine or the Faculty of Addiction Psychiatry, or a prescriber of equivalent training and experience as from time to time approved by the OPS

☐ At least 2 current ECGs giving corrected QT intervals (QTc) taken on 2 separate days within a 4-to-8-week period before date of submission of the application *(Not required for buprenorphine applications)*.

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SECTION D – ATTACHMENTS (CONT.)

- ☐ at least 2 recent urine drug screens (UDS) taken on 2 separate days within a 4-to-8-week period before date of submission of the application
- ☐ current trough methadone levels (accompanied by laboratory reference range and interpretation), with information on when trough level was taken in relation to last dose *(Not required for buprenorphine applications)*.

SECTION E – 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)