Application for Approval to Prescribe or Supply a Schedule 8 Medicine-Pain Management

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

NSW GOVERNMENT

This form is to be used to apply for an approval to prescribe or supply a Schedule 8 medicine for pain management.

Practitioners can apply online through the SafeScript NSW portal. Applying via the portal allows a practitioner to receive real-time approval or a notification if an application needs to be reviewed by the NSW Ministry of Health. Practitioners can also monitor the progress of their online application.

Relevant treating specialists include practitioners with the following Ahpra specialties:

- For palliative treatment: Palliative medicine (including paediatric palliative medicine) and Medical oncology (including paediatric medical oncology)
- For cancer pain and chronic non-cancer pain: Pain medicine, Rehabilitation medicine (including paediatric rehabilitation medicine) and Medical oncology (including paediatric medical oncology)

Co-management arrangements and Transfer of care agreements

A **co-management arrangement** is an agreement that that is established between a relevant medical specialist and another prescriber. The other prescriber is usually a general practitioner, other registered medical practitioner, or nurse practitioner who agrees to partner in the care of a patient. This arrangement improves access to treatment and adds benefit to patients by combining continuity of care by their regular prescriber with specialist intervention and oversight.

Under a co-management arrangement, the relevant treating specialist is responsible for providing detailed advice and support to the other prescriber. This includes specific instruction about the treatment arrangements, pharmacotherapy treatment decisions such as medicine and dose, and ongoing review arrangements as deemed clinically appropriate. Both practitioners involved in the patient's care are responsible for ensuring that prescriptions are issued by one prescriber at any given time.

A **transfer of care agreement** involves a relevant treating specialist initiating treatment and ensuring the patient is stable before directing another prescriber to continue care. Changes in medicine or increases in dose should be supported by the treating specialist.

Pharmaceutical Services recognises these arrangements when considering applications for approval from GPs, other registered medical practitioners and nurse practitioners.

For more information, please visit Pharmaceutical Services website

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Before starting the application:

- **If the patient is currently enrolled on the Opioid Treatment Program (OTP)**, please make sure that you have obtained written agreement from the authorised OTP prescriber for the proposed treatment.
- Ensure that all opioid medications currently used by the patient are included when calculating the total oral morphine equivalent daily dose (oMEDD).
- Please make sure you have sought support from a relevant treating specialist if:
  - the patient is on OTP (and requires long term pain management)
  - applying for injectable opioids*
  - oMEDD ≥ 300 mg*
  - oMEDD is between 100mg to 300mg and you are not listed as a relevant specialist (outlined above)
  - applying for a non-opioid S8 drug
  - applying for 'Other' indication

* Support will not be required for palliative treatment if you are a relevant treating specialist

You may be requested to provide supporting documents. You will be notified if additional documentation is required. **Do not email or send documents unless requested**.

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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 is in accordance with currently published and approved Product Information (PI), recommendations from the RANZCP, RACP and RACGP, best practice guidelines and current evidence-based medicine standards and that practitioners work within their scope of practice. Treatment should be in accordance with a management plan, which considers all available treatment options, including non-pharmacological strategies.

Applicants are advised to consider if the patient would benefit from a review by an **addiction medicine specialist** to manage any perceived drug dependence concerns.

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)** in the **Metropolitan Area: (02) 8382-1006; in Regional, Rural & Remote NSW areas: 1800 023 687**, available 24/7. **This advice line cannot provide support for an application for an approval.**

The NSW Ministry of Health does not endorse self-administration of injectable opioids or administration by family members.

For Opioid prescribing recommendations in General Practice as published by ACI Pain Management Network, and for more information about the role of opioids in chronic non-cancer pain and further resources go to http://www.aci.health.nsw.gov.au

Oral Morphine Equivalent Daily Dose (oMEDD) is the opioid dosage as compared to oral morphine. To calculate the oMEDD, go to Opioid dose equivalence calculation table or Opioid calculator

Please ensure all opioid medications currently used by the patient are included when calculating total oMEDD.

Further information is available on the Pharmaceutical Services website.

Privacy Statement: *The information set out in this form is required by the NSW Ministry of Health for the issuance of an approval 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 approvals 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 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 Services Unit: Tel: **(02) 9424 5923** or email: **MOH-S8Auth@health.nsw.gov.au**

Submitting the application:

Fax completed form to the Pharmaceutical Services Unit: **(02) 9424 5889** or email: **MOH-S8Auth@health.nsw.gov.au**

Practitioners can apply online through the **SafeScript NSW** portal and in many cases receive real time approval.

Processing Time:

Please allow up to **7 business days** for the processing of applications.

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SECTION A – PRESCRIBER DETAILS

Prescriber Name: (as displayed in AHPRA)

First Name(s): _____ 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(s): _____ Middle Name(s): _____

Family Name: _____

Patient also known as: (if applicable)

First Name(s): _____ 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 – CO-MANAGEMENT OR TRANSFER OF CARE

☐ I am a medical practitioner or nurse practitioner applying to prescribe or supply under a co-management arrangement or transfer of care agreement.

SECTION D – PRE-QUESTIONS

1. IS THE PATIENT CURRENTLY ENROLLED ON THE OPIOID TREATMENT PROGRAM (OTP)?

☐ **No**. Go to **question 2**

☐ **Yes**. I am the authorised OTP prescriber. Go to **question 2**

☐ **Yes. I am NOT the authorised OTP prescriber.** Has the patient been reviewed by the authorised OTP prescriber and written agreement to the proposed treatment obtained?

- ☐ **Yes**. Go to **question 2**
- ☐ **No**. Contact the authorised OTP prescriber and obtain written agreement before submitting this application. **This application cannot proceed** and will not be considered until written agreement is obtained.

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2. DO YOU CONSIDER THIS PATIENT TO BE DRUG DEPENDENT?

A 'drug dependent person' means a person who has acquired, as a result of repeated administration of:

(a) a drug of addiction, or

(b) a prohibited drug within the meaning of the Drug Misuse and Trafficking Act 1985,

*an overpowering desire for the continued administration of such a drug (**section 27 of the Poisons and Therapeutic Goods Act 1966**).*

☐ **Yes.**

☐ **No.**

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3. IF THE PATIENT IS NOT CONSIDERED TO BE DRUG DEPENDENT, HAVE THEY USED OR ARE THEY EXPECTED TO USE *ANY OF THE DRUGS LISTED BELOW* CONTINUOUSLY FOR MORE THAN TWO MONTHS?

- any Schedule 8 medicine intended for administration by injection
- any Schedule 8 medicine for inhalation, or for spray or application to mucous membranes
- buprenorphine (except transdermal preparations)
- hydromorphone
- methadone
- alprazolam
- flunitrazepam

☐ **Yes. Approval required.** Go to **Section E: Drug Authorisation Details**

☐ **No. Approval is NOT required** for this patient at this time. Prescribing may continue without approval from NSW Ministry of Health

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SECTION E – DRUG AUTHORISATION DETAILS

Drug 1:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 2:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Drug 3:

Drug name: _____

Route of administration: _____

Maximum daily dose: _____ mg oMEDD: _____

Total oMEDD: _____ Please calculate the total oMEDD the patient will be receiving, including any other opioid medicines not listed on this application. For non-opioid drugs, Total oMEDD details are to be left blank.

INDICATIONS FOR PRESCRIBING OR SUPPLY

☐ **Palliative treatment.** Go to **Section F: Declaration**

Palliative treatment means the palliative treatment of a patient who has:

(a) an incurable, progressive, far-advanced disease or medical condition, and

(b) a prognosis of a limited life expectancy, with death expected within the next 2 years, because of the disease or medical condition.

☐ **Cancer related pain**

What is the expected duration of treatment with the requested medicine(s)? _____ months

☐ **Chronic non-cancer pain**

What is the expected duration of treatment with the requested medicine(s)? _____ months

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SECTION E – DRUG AUTHORISATION DETAILS (cont.)

INDICATIONS FOR PRESCRIBING OR SUPPLY (CONT.)

☐ **Other** (please specify) _____

What is the expected duration of treatment with the requested medicine(s)? _____ months

Do you have support from a relevant treating specialist for this treatment?

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

☐ **No**. Refer the patient to a relevant treating specialist and obtain support. Go to **Section F: Declaration**

SECTION F – DECLARATION

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

Please tick the option which applies:

☐ **I confirm that I am the relevant treating specialist or, where required, that I have support from a relevant treating specialist for the proposed treatment.**

☐ **I confirm I will seek support from a relevant treating specialist to support this application.**

☐ **I confirm that I do not have support from a relevant treating specialist.**

Print and Sign

Signature: _____ Date: _____ (dd/mm/yyyy)

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