NSW Health

Application for Approval to Prescribe or Supply a Schedule 8 Psychostimulant

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 psychostimulant (dexamfetamine, lisdexamfetamine or methylphenidate) to a child or adult.

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.

- **If you are a paediatrician, psychiatrist, or neurologist** prescribing or supplying for the treatment of **Attention Deficit Hyperactivity Disorder (ADHD)**, to a non-drug dependent person, within the daily dose limits (dexamfetamine 50mg, lisdexamfetamine 70mg or methylphenidate 108mg) you are authorised under a **class authority. YOU DO NOT** need to apply for individual patient approval. All prescriptions must be endorsed with the class authority number **"CA2023"**.

  An individual patient approval is required when criteria fall outside the conditions of the class authority.

- **If you are respiratory & sleep medicine specialist** prescribing or supplying for the treatment of a **sleep disorder**, to a non-drug dependent person, within the daily dose limits (dexamfetamine 60mg, lisdexamfetamine 70mg or methylphenidate 108mg) you must obtain individual patient approval. You do not require further support for this treatment.

- **If you are an Other Designated Prescriber (ODP)** (as endorsed by NSW Ministry of Health) prescribing or supplying for the treatment of **Attention Deficit Hyperactivity Disorder (ADHD)** in a child or adolescent, individual patient approval is required, and the following criteria must be met:
  - for dexamfetamine and methylphenidate, patients must be aged 4 to 17 years (inclusive)
  - for lisdexamfetamine, patients must be aged 6 to 17 years (inclusive)
  - prescribed daily doses must not exceed dexamfetamine 50mg, lisdexamfetamine 70mg or methylphenidate 108mg

- **If you are a medical practitioner** applying to prescribe or supply under a co-management arrangement or transfer of care agreement you must obtain individual patient approval.

Co-management arrangements and Transfer of care agreements

A **co-management arrangement** is an agreement 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.

*Under the current Poisons and Therapeutic Goods legislation, a Nurse Practitioner cannot lawfully prescribe psychostimulant medicines or compounded Schedule 8 substances

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Co-management arrangements and Transfer of care agreements (cont.)

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 or other registered medical practitioners

Applications from medical practitioners for initiation of psychostimulant therapy without the recommendation, direction, or endorsement of a relevant treating specialist will generally not be approved.

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 psychostimulant treatment.

If the application is for a high dose or an 'Other' indication, support for this treatment will be required. You may be requested to provide supporting documentation, examples of which may include a clinical report, growth charts, assessment of functional impairment and behavioural assessments. You will be notified if additional documentation is required. Please 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. 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: 1800 023 687, available 24/7. **This advice line cannot provide support for an application for an approval**.

For more information, please visit 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 to **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

SECTION C – CO-MANAGEMENT

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

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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.**

SECTION E – DRUG AUTHORISATION DETAILS

Please tick applicable box(es)

☐ dexamfetamine	Maximum daily dose: _____ mg
☐ lisdexamfetamine	Maximum daily dose: _____ mg
☐ methylphenidate	Maximum daily dose: _____ mg

Does the daily dose exceed

- 50mg for dexamfetamine
- 70mg for lisdexamfetamine
- 108mg for methylphenidate

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SECTION E – DRUG AUTHORISATION DETAILS (CONT.)

☐ **No**. Go to **Section F: Indication**

☐ **Yes**. Do you have written support from a relevant treating specialist?* In certain circumstances you may be requested to provide additional information to support this application. **You will be notified if additional documentation is required**.

* **Note**: ***If you are respiratory & sleep medicine*** *specialist applying to prescribe or supply for the treatment of a* ***sleep disorder****, to a non-drug dependent person, within the daily dose limits (dexamfetamine 60mg, lisdexamfetamine 70mg or methylphenidate 108mg) you do not require support for this treatment. Please answer 'No' to this question.*

☐ **Yes**

☐ **No**

SECTION F – INDICATION

Please tick the applicable box. Only one indication may be selected

☐ Attention Deficit Hyperactivity Disorder (ADHD) *All patients must meet the criteria for Attention Deficit Hyperactivity Disorder (ICD-11 or DSM-5)*

☐ Narcolepsy ☐ Excessive somnolence

☐ Other sleep disorder, please specify _____

☐ Treatment resistant depression ☐ Binge eating disorder (BED) in adults

☐ Palliative care/Cancer related fatigue ☐ Traumatic brain injury ☐ Stimulant use disorder

☐ Other indication, please specify _____

Do you have support from a relevant treating specialist for this treatment? In certain circumstances you may be requested to provide additional information to support this application. **You will be notified if additional documentation is required**.

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

☐ **No**. Please obtain support for treatment from a relevant treating specialist. Go to **Section G: Declaration**

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SECTION G – 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.**

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