STRICTLY CONFIDENTIAL PHARMACEUTICAL SERVICES NSW MINISTRY OF HEALTH

APPLICATION FOR AUTHORITY TO PRESCRIBE BUPRENORPHINE (11/12)

(IN ACCORDANCE WITH SECTION 29 UNDER THE POISONS AND THERAPEUTIC GOODS ACT 1966)

REFER TO INSTRUCTIONS ON THE REVERSE SIDE. **PLEASE USE BLOCK LETTERS.**

Patient ID No : START DATE : TRANSFER : Y / N *[OFFICE USE ONLY]*

1. PATIENT SURNAME : _____

2. GIVEN NAMES : _____
(first and second)

3. ALSO KNOWN AS : _____
(surname)

_____
(first and second)

4. ADDRESS: _____

_____

5. SUBURB : _____

6. POSTCODE : ___ ___ ___ ___

7. DATE OF BIRTH : ___ ___ / ___ ___ / ___ ___ ___ ___

8. SEX : ☐ M ☐ F

9. IDENTIFICATION VERIFIED *(see 'Instructions')* :
☐ Y ☐ N

10. Is the patient CURRENTLY on a buprenorphine or methadone program in NSW? *(Tick one box only)*
☐ Y, buprenorphine ☐ N ⇨ *GO TO Q.19*
☐ Y, methadone

11. Are you the patient's CURRENT prescriber?
☐ Y ☐ N ⇨ *GO TO Q.15*

12. Indicate below the purpose of this application :
(Tick one box only)

☐ To INCREASE the MAXIMUM AUTHORISED DOSE of buprenorphine ⇨ *GO TO Q.32*

☐ To TRANSFER the patient from METHADONE treatment ⇨ *GO TO Q.13*

Note: For transfers from methadone to buprenorphine treatment with the same prescriber, do not lodge an '*Exit from Methadone/Buprenorphine Treatment*' form for current methadone program

13. Date of LAST DOSE of methadone :

___ ___ / ___ ___ / ___ ___ ___ ___

14. LAST DOSE of methadone : ___ ___ mg ⇨ *GO TO Q.30*

15. Specify the NAME of the patient's CURRENT prescriber :

_____

16. Is the patient TRANSFERRING from GAOL?
☐ Y ☐ N ⇨ *GO TO Q.30*

17. Date of LAST DOSE dispensed on GAOL PRESCRIPTION, including any takeaways :
(Please ensure this is completed correctly – *see 'Instructions'*)

___ ___ / ___ ___ / ___ ___ ___ ___

18. LAST DOSE : ___ ___ ___ mg ⇨ *GO TO Q.30*

19. Has the patient PREVIOUSLY been on a buprenorphine or methadone program in NSW?
☐ Y, *specify last prescriber* _____
☐ N

20. Is the patient TRANSFERRING from ANOTHER STATE or TERRITORY?
☐ Y, *specify (eg. Vic.)* _____ ☐ N

If **YES**, attach statement signed by interstate prescriber showing dose and date of last dose (incl. takeaways)

21. Is the patient of ABORIGINAL or TORRES STRAIT ISLANDER origin?
☐ 1 Yes, Aboriginal
☐ 2 Yes, Torres Strait Islander
☐ 3 Yes, both Aboriginal and Torres Strait Islander
☐ 4 No

22. In which COUNTRY was the patient born?
☐ 1100 Australia
☐ other, *specify* _____

23. What is the patient's PREFERRED LANGUAGE?
☐ English
☐ other, *specify* _____

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Patient's Name: _____ ***(prescriber to complete)***

24. What is the patient's PRINCIPAL SOURCE of INCOME? (*Tick one box only)*

- ☐ 01 full-time employment
- ☐ 02 part-time employment
- ☐ 03 temporary benefit, eg. unemployment
- ☐ 04 pension, eg. aged, disability
- ☐ 05 student allowance
- ☐ 06 dependent on others
- ☐ 07 retirement fund
- ☐ 98 other
- ☐ 08 no income

25. What is the patient's PRIMARY opioid drug of dependence? *(Tick one box only)*

- ☐ heroin
- ☐ morphine
- ☐ oxycodone
- ☐ other, *specify* _____

26. What DRUG(S), <u>other than opioids</u>, does the patient perceive as being a concern? *(Tick the appropriate box/es)*

- ☐ 990 none
- ☐ 010 alcohol
- ☐ 310 amphetamines
- ☐ 240 benzodiazepines
- ☐ 030 cannabis
- ☐ 393 cocaine
- ☐ 345 ecstasy
- ☐ other, *specify* _____

27. Is the patient pregnant? *(see 'Instructions')*

☐ Y ☐ N ☐ not applicable

28. Is the patient or the patient's opioid-using partner HIV positive?

☐ Y ☐ N ☐ not stated

29. If patient is aged 16 YEARS TO UNDER 18 YEARS, write below the name of the APPROVED BUPRENORPHINE PRESCRIBER providing SECOND OPINION. <u>Report must be attached</u>.

_____

30. Proposed STARTING DOSE of buprenorphine (determined in accord with clinical assessment) : ___ ___ mg

31. Proposed STARTING DATE : ___ ___ / ___ ___ / ___ ___ ___ ___

32. Expected MAXIMUM DOSE of buprenorphine : ___ ___ mg

33. Proposed ADMINISTRATION POINT :

_____

_____

[OFFICE USE ONLY : _____ *]*

I, the undersigned, declare that the patient's opioid dependence has been established using CURRENT BEST PRACTICE*, and that the patient has been assessed suitable for BUPRENORPHINE treatment. A TREATMENT AGREEMENT* has been completed. (**see 'Instructions')*

Prescriber's Signature : _____

Prescriber's Name : _____

[OFFICE USE ONLY : _____ *]*

Address : _____

Date : _____

Ph : _____ Fax : _____

<u>TO BE COMPLETED BY PATIENT</u>

I hereby declare that I have not knowingly supplied any false particulars above and that I am
*NOT CURRENTLY ON ANY OTHER / TRANSFERRING FROM ANOTHER methadone or buprenorphine program. I have been explained the nature of buprenorphine treatment and the potential side effects of buprenorphine, and I consent to being treated with buprenorphine. I also understand that the particulars I have supplied are relevant and necessary to my treatment and the management of the NSW Opioid Treatment Program, and will be stored confidentially on a central register.

Name : _____

Signature : _____

Date : _____

**Cross out whichever does not apply*

INSTRUCTIONS

Place a tick in the appropriate box(es) or write in the spaces provided. Ensure that all applicable questions are completed.

Note: The term 'NSW Clinical Guidelines' is used below to denote the *New South Wales Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment of Opioid Dependence*.

Q.1. **SURNAME**: That appearing on the patient's Medicare Card.

Q.2. **GIVEN NAMES**: Provide all given names.

Q.3. **ALSO KNOWN AS**: Other names used by the patient.

Q.4. **ADDRESS**: Residence at which the patient may be contacted. NFA ('no fixed address') or postal box address is not sufficient.

Q.8. **SEX**: Refers to the biological differences between males and females. For transsexuals undergoing a sex change operation, record their current sex status (ie. that as at the date of this application).

Q.9. **IDENTIFICATION VERIFIED**: A patient's identity must be verified with appropriate documentation, eg. passport; photo licence; gaol card showing photo, date of birth, MIN number and signature; Proof of Age card. Refer to the *NSW Clinical Guidelines* for other acceptable forms of ID. Record on the patient's file the form of identification provided.

Q.10. **CURRENT TREATMENT**: Any treatment received under the NSW Opioid Treatment Program.

Q.12. **AUTHORISED MAXIMUM DOSE**: Applications to prescribe in excess of 32mg are submitted to the Pharmacotherapy Credentialling Subcommittee. Contact the PCS Secretary on (02) 9391 9050 for updated application form and further details.

Q.14. **LAST DOSE**: If transferring a patient to methadone, refer to the *NSW Clinical Guidelines* for information on dosing.

Q.17. **TRANSFER FROM GAOL**: The 'last dose' refers to the last dose dispensed on the gaol prescription before a
Q.18. dose is dispensed on the new (community) prescriber's prescription. It includes any takeaways issued for use after transfer and any prescription forwarded to the new administration point. The details of dose and date of last dose for patients transferring from gaol should be confirmed with the gaol prescriber.

Q.19. **PREVIOUS PROGRAM**: Any treatment received under the NSW Opioid Treatment Program.

Q.20. **TRANSFER FROM OTHER STATE/TERRITORY**: That is, the patient is currently on an authorised program in a State or Territory other than NSW.

Q.21. **ABORIGINAL/TORRES STRAIT ISLANDER ORIGIN**: An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Q.23. **PREFERRED LANGUAGE**: The language (including sign language) most preferred by the patient for communication.

Q.24. **PRINCIPAL SOURCE OF INCOME**: The patient's source of income from which he or she legally derives most (equal to or greater than 50%) of his or her total income. If the person has multiple sources of income and none amounts to 50%, the one which contributes the largest percentage should be recorded.

Q.27. **PREGNANCY**: Refer to the *NSW Clinical Guidelines* for information on the treatment of pregnant patients. Tick 'not applicable' if the patient is male.

Q.28. **HIV**: People with HIV and their opioid-using partners have priority access to opioid treatment programs.

Q.29. **16 YEARS TO UNDER 18 YEARS**: For patients who are aged 16 to less than 18 years of age at the time of application, a second opinion from an approved buprenorphine prescriber must be obtained and the relevant report attached to the application form.

Q.30. **STARTING DOSE**: The suggested starting dose is 4 to 8 mg. Refer to the *NSW Clinical Guidelines* for doses used when transferring a patient from methadone to buprenorphine.

Q.33. **ADMINISTRATION POINT**: All patients should commence dosing in a well supervised setting (eg. specialist clinic). Refer to the *NSW Clinical Guidelines* for more details.

* **CURRENT BEST PRACTICE**: Refer to the *NSW Clinical Guidelines* for current best practice in establishing opioid dependence.

* **TREATMENT AGREEMENT**: Under the *NSW Clinical Guidelines*, all patients entering an opioid treatment program must sign a NSW Health Treatment Agreement before commencing treatment.

PLEASE *SEND* or *FAX* COMPLETED FORM TO:

CHIEF PHARMACIST
PHARMACEUTICAL SERVICES
NSW MINISTRY OF HEALTH
LOCKED MAIL BAG 961
NORTH SYDNEY NSW 2059

FACSIMILE (02) 9424 5885
TELEPHONE (02) 9424 5921

If faxing form, DO NOT SEND ORIGINAL. Do not fax this 'Instructions' page.