CONFIDENTIAL

Application for authorisation to administer, prescribe or supply Schedule 8 medicine for Treatment for Opioid Use Disorder under section 59E of the *Poisons Act 1971*

Tasmanian Government

DETAILS MUST BE COMPLETED **LEGIBLY** TO PREVENT DELAY
TICK DATA AS APPROPRIATE | PLEASE USE BLOCK LETTERS

Applications are unable to be assessed if all requested information on the form is not completed.

Patient Details						
First Name		**Middle Name/s**		**Surname**		
Date of Birth (DD/MM/YYYY):	/ /	**Gender:**	☐ Male	☐ Female	☐ Non-binary	
Patient Residential Address						
Unit number:		**Street number:**		**Street name:**		
Suburb:		**State:**		**Post Code:**		
Please provide any additional information below:						

Parent / Carer details (if patient under 18 years old)			
Parent/Carer 1 Full name:		**Date of Birth (DD/MM/YYYY):**	/ /
Parent/Carer 2 Full name:		**Date of Birth (DD/MM/YYYY):**	/ /

Prescriber Details			
Full Name:			
Ahpra Number:		**Prescriber Number:**	
Practice Address:			
Telephone:	( )		

Medication Details	
Requested Schedule 8 Medicines	
Medicine Name	**Directions for use (must include dose, frequency and formulation)**

All correspondence to be marked "Confidential" and sent to:
Pharmaceutical Services Branch, Department of Health, GPO BOX 125, Hobart TAS 7001
For further information: Tel: (03) 6166 0400, Fax: (03) 6173 0820, Email: pharmserv@health.tas.gov.au

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Treatment Details	
☐	I certify this patient satisfies the diagnostic criteria for opioid use disorder (DSM-5), and in my opinion, opioid replacement therapy is required, and treatment will be provided in accordance with the relevant clinical guidelines.
Drug(s) of Dependence – substance(s) contributing to the dependence:	
Name of dosing site(s):	

Declarations – please tick to notify or leave blank if not applicable			
The patient in my opinion:		☐ **Is** drug dependent	
	Grounds for drug dependency:	☐ Iatrogenic	☐ Illicit
Does the patient have current, or a history of intravenous drug use (IVDU):		☐ Yes, current IVDU ☐ Yes, history of IVDU	
I have reason to believe the patient:		☐ Is exhibiting drug-seeking behaviour ☐ Has a history of drug-seeking behaviour	
The patient has previously received opioid replacement therapy as part of any treatment for opioid use disorder (DSM-5):		☐ Yes	

I acknowledge an application for authorisation to treat a person with Schedule 8 medicine(s) is a requirement of the *Poisons Act 1971* and I have informed the patient I am required to seek authorisation for this medicine(s). I acknowledge that as part of the risk-informed assessment of my application the Secretary may seek further information relating to the medical history and treatment of the patient including a documented treatment plan. I acknowledge if an authority is granted it does not act as clinical endorsement for the treatment I am proposing. I also acknowledge in making this application I am asserting in my opinion as a registered health practitioner this treatment is clinically appropriate for this patient and will be provided in accordance with the relevant clinical guidelines.

Signature of prescriber:		**Date of application:**	/ /

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