

ALL DETAILS MUST BE COMPLETED AND ALL DETAILS MUST BE LEGIBLE OR CONSIDERATION OF THIS APPLICATION MAY BE DELAYED.

FAX to: 02 6205 0997

Please tick if application is URGENT

PRESCRIBER DETAILS	PATIENT DETAILS
Name	Name
Practice and address	Address
Registered Specialty	Date of Birth
Phone: _____ Fax: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

SPECIFIC CONDITION OF PATIENT AND SPECIALIST SUPPORT (if required):

Is this patient Drug Dependent*? Yes No
If patient is drug dependent, please complete controlled medicines approval by drug with appropriate specialist support or approval to prescribe methadone or buprenorphine for treatment of drug-dependency.

APPROVAL IS REQUESTED TO PRESCRIBE BY CATEGORY	OR	APPROVAL IS REQUESTED TO PRESCRIBE BY DRUG
<input type="checkbox"/> Category 1 <input type="checkbox"/> Category 2A <input type="checkbox"/> Category 2B <input type="checkbox"/> Category 2C <input type="checkbox"/> Category 2D <input type="checkbox"/> Category 3A <input type="checkbox"/> Category 3B <input type="checkbox"/> Category 4A <input type="checkbox"/> Category 4B <input type="checkbox"/> Category 5A <input type="checkbox"/> Category 5B <input type="checkbox"/> Category 5C <input type="checkbox"/> Category 5D	<p>OR</p> <p>(Complete CATEGORY or DRUG section only)</p>	Controlled Medicine: _____ Form and Strength: _____ Prescribed (maximum) daily dose: _____ Quantity: _____ Repeats: _____ For Opioid Maintenance Treatment Only: <input type="checkbox"/> Commencing today: __/__/____ <input type="checkbox"/> Continuation for 12 months <input type="checkbox"/> Temporary transfer (Please attach further information such as evidence of usual dose). Dates: __/__/____ to __/__/____ Number of takeaways per week: _____

PRESCRIBER DECLARATION (please tick):

I understand that the issue of an approval does not indicate Chief Health Officer support or endorsement of a proposed treatment.

I declare that I am prescribing in accordance with the Controlled Medicines Prescribing Standards and that failure to do so may render me liable for enforcement action under the *Medicines Poisons and Therapeutic Goods Act 2008*.

Signature of prescriber: _____ Date: _____

OFFICE USE ONLY

Approved DAPIS Reference Number: _____ Refused

Signature: _____ Date: _____ Approval Term: __/__/____ to __/__/____

EXPLANATORY NOTES

This form must be used by prescribers to apply to the Chief Health Officer for approval to prescribe a controlled medicine when a patient is drug-dependent, has been on any controlled medicine within the last two months or treatment is expected to last longer than two months. All applications to prescribe a controlled medicine will be assessed and approved in accordance with the Controlled Medicines Prescribing Standards (the Prescribing Standards). Completed applications contain sensitive information and are considered 'medical in-confidence'.

*** A drug-dependent person** is defined in the Medicines, Poisons and Therapeutic Goods Regulation 2008. It is acknowledged that the determination of a drug dependent person can be subjective; however it is a clinical decision of the treating practitioner.

The Controlled Medicines Prescribing Standards (Prescribing Standards) are made under the Medicines, Poisons and Therapeutic Goods Regulation 2008 for the purposes of establishing the conditions and criteria under which a prescriber may prescribe controlled medicines under a Chief Health Officer (CHO) category approval or drug approval. A copy of the Prescribing Standards is accessible from <http://www.health.act.gov.au/public-information/businesses/pharmaceutical-services/controlled-medicines>.

Summary of controlled medicines approval by category - These categories are to be read in conjunction with the Prescribing Standards:

Category 1

Controlled opioid medicines to treat a person with **chronic (non-cancer) pain**.

Dose \leq 100mg oral morphine equivalent daily (MEqD) applies. See table below.

Category 2

Controlled opioid medicines to treat a person with pain due to **active malignancy or life limiting disease state** or considered on a case by case basis or where the prognosis might reasonably be expected to be **12 months or less**.

2A For general practitioners a dose of \leq 160mg MEqD applies.

2B For general practitioners a dose of \leq 300mg MEqD applies with appropriate specialist support required.

2C For pain or addiction or palliative care specialist or oncologist or other specialist as considered appropriate or Credentialed General Practitioner or palliative care nurse practitioner.

2D For pain or addiction or palliative care specialist or oncologist or other specialist as considered appropriate or Credentialed General Practitioner or palliative care nurse practitioner or prescriber endorsed to treat drug dependency or drug and alcohol nurse practitioner to treat drug-dependent patients, in accordance with a collaborative approach between treating teams, as described in the Controlled Medicines Prescribing Standards.

Category 3

Controlled opioids medicines to treat a person with **drug-dependency**.

3A Dose of \leq 120mg oral methadone applies.

3B Dose of \leq 32mg oral buprenorphine applies.

Category 4

Controlled benzodiazepine medicines to treat a person with a licensed indication or severe insomnia.

4A Specialist use of alprazolam to treat a person with panic disorder or short term symptomatic anxiety (\leq 10mg daily).

4B Specialist use of flunitrazepam to treat a person with severe insomnia \leq 2mg at night.

Category 5

Controlled stimulant medicines to treat a person with Attention Deficit Hyperactivity Disorder.

5A For general practitioners a dose threshold applies for 4 – 19 year old patients with appropriate specialist support required.

5B For general practitioners a dose threshold applies patients 19 years or older with appropriate specialist support required.

5C For specialists a dose threshold applies for 4 – 19 year old patients.

5D For specialists a dose threshold applies patients 19 years or older.

Oral morphine equivalent dose (MEqD)					
Drug	Formulations	Conversion ratio*	MEqD 100mg (daily)	MEqD 160mg (daily)	MEqD 300mg (daily)
Morphine	oral (mg/day)	1 : 1	100mg daily	160mg daily	300mg daily
Hydromorphone	oral (mg/day)	1 : 5	20mg daily	32mg daily	60mg daily
Buprenorphine	transdermal (microg/hr)	1 : 2	50mcg/hr	80mcg/hr	150mcg/hr
Fentanyl	transdermal (microg/hr)	1 : 3.6	28mcg/hr	45mcg/hr	84mcg/hr
Oxycodone	oral (mg/day)	1 : 1.5	66mg daily	107mg daily	200mg daily
Tapentadol	oral (mg/day)	1 : 0.4	250mg daily	400mg daily	750mg daily

Source: Australian Medicines Handbook (2016)

COMPLETED FORMS TO BE SUBMITTED TO THE CHIEF HEALTH OFFICER

Phone: 02 6205 0998

Fax: 02 6205 0997

Email: hps@act.gov.au

Post: Locked Bag 5005, Weston Creek ACT 2611

#Please ensure all posted applications are marked confidential.