

Appendix C

APPLICATION FOR AUTHORITY TO PRESCRIBE A RESTRICTED S8 SUBSTANCE FOR THE TREATMENT OF ADDICTION

Poisons Control ~ Fax: 8922 7200 Phone: 8922 7341

New application Renewal Amending existing authorisation Cessation

SCHEDULE 8 DRUG

Name of drug: Buprenorphine (s/l tab) Methadone liquid
 Buprenorphine/naloxone (s/l tab)

Agreed treatment plan: Maintenance (24 months authority) Withdrawal (3 weeks authority)

Pharmacy.....Initial dose (mg).....Date of first dose...../...../.....

If amendment: Withdrawal to Maintenance Maintenance to Withdrawal
 Methadone to Buprenorphine Buprenorphine to Methadone
 Change of Buprenorphine form

If transfer from another prescriber: Transfer within the NT Transfer from Interstate

Name of former prescriber:

PATIENT DETAILS (please print clearly)

Surname:.....Given names:.....

Pseudonym:..... Date of birth:/...../.....Sex: M F

Name of parent or guardian (if child under 18)Transgender:

Address:.....

Medicare Card No:..... Health Care Card No:.....

Indigenous status non-Indigenous Indigenous

REASON FOR CESSATION (please tick only one)

| | |
|--|---|
| <input type="checkbox"/> Mutual agreement (program incomplete) | <input type="checkbox"/> Transfer interstate – specify..... |
| <input type="checkbox"/> Left against medical advice | <input type="checkbox"/> Transfer to other NT prescriber..... |
| <input type="checkbox"/> Request by Medical Officer | <input type="checkbox"/> Completed program |
| <input type="checkbox"/> Ceased to pick up dose | <input type="checkbox"/> Hospitalisation |
| <input type="checkbox"/> Imprisonment | <input type="checkbox"/> Referred to other non-drug treatment |
| <input type="checkbox"/> Deceased | <input type="checkbox"/> Other – specify..... |

PRESCRIBER

Prescriber name:..... Prescriber No.....

Address and phone number.....

Prescribers signature..... Date/...../.....

Are you a GP co-prescriber?.....Y/N

If yes, Supervising Prescribers name.....

Supervising Prescribers address and phone number.....