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| Is the product listed on the Australian Register of Therapeutic Goods (ARTG): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | | | |
| 1. If yes: complete this form for WA Department of Health approval. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. If no: has TGA approval been granted: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | | | |
| * + If yes: provide the expiry date of TGA approval: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Attach copy of TGA approval | | | | | | | | |
| **and**  complete this form for WA Department of Health approval | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * + If no: **DO NOT** complete this form, instead apply through the TGA Special Access Scheme (SAS) online system at: <https://sas.tga.gov.au> (NB: The TGA website is a single online portal for applications) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Patient details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | | | |  | | | | | | | | | | Surname: | | | | | | |  | | | | | | | | | | | | | | DOB | | |  | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Suburb: | | | |  | | | | | | | | | Postcode | | | | |  | | | | | | | Gender: | | | | | Male  Female Unspecified | | | | | | | | | | | | | |
| Also known as (alias) (if applicable): | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | |
| Diagnosis(es): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Indications: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical justification for use of product: (e.g. details of previous treatment including reasons why Cannabis Based product is to be used in this circumstance) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Medicinal cannabis product details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brand Name: | | | | |  | | | | | | | | | | Sponsor supplier: | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Active ingredient(s): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dosage form (e.g. solution, capsule): | | | | | | | | | | | |  | | | | | | | | | | | | | | Strength (e.g. 1mg/mL): | | | | | | | | | |  | | | | | | |
| Route of administration (e.g. oral, inhaled): | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Dose & frequency including maximum daily dose: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Planned duration of treatment: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Prescribing health practitioner details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | | |  | | | | | | | | | | | | | | Surname: | | | | | | | | | | | | | | | | |  | | | | | | |
| AHPRA Registration No: | | | | | | | | | |  | | | | | | | Health Practitioner Type: | | | | | | | | | | | | | | | | |  | | | | | |
| Email: |  | | | | | | | | | | | | | | | | Specialty (if applicable): | | | | | | | | | | | | | | | | |  | | | | | |
| Fax: |  | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | | | | | | |  | | | | | |
| Principal Practice Name and address: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Co-prescriber** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | |  | | | | | | | | | | | | | | | | | Surname: | | | | | | | | |  | | | | | | | | | | |
| Health Practitioner type: | | | | | | | | |  | | | | | | | | | | | Fax: | | | | | | | | |  | | | | | | | | | | |
| Email: | | | | | |  | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | |  | | | | | | |
| Principal practice name: | | | | | |  | | | | | | | | | | | | | | | | | Principal practice address: | | | | | | | | | |  | | | | | | |
| Primary prescriber (renewals will be sent to primary prescriber): | | | | | | | | | | | | | | | | | | | | | | | | Prescribing health practitioner  Co-prescriber | | | | | | | | | | | | | | | | | |

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| 1. **Additional information** (Please attach consultant support and details of intended management and monitoring plan) | | | | | | | |
| Is this patient pallative or suffering a terminal illness (life expectancy ≤ 12 months)? | | | | | | | |
| No | Yes, specify | |  | | | |
|  | | |  | | | |
| Does this patient have a history of psychosis or another serious psychiatric comorbidity? | | | | | | | |
| No | Yes, specify | |  | | | | | |
|  | |  | | | | | | | |
| Does this patient have a history of recent (last 5 years) substance abuse or misuse? | | | | | | | | | |
| No | Yes, specify | |  | | | | | |
|  | | |  | | | | | |
| Is consultant support available? | | | | | | | | |
| N/A, consultant is prescriber | | | | No | Yes, please attach copy of consultant advice. | | | | |
| Is there a written management and monitoring plan? | | | | | | | | | |
| No | Yes, please attach copy of management and monitoring plan. | | | | | | | | |
| In this patient being treated with any other Schedule 8 medicines? | | | | | | | | | |
| No | Yes, specify | |  | | | | | |
|  | |  | | | | | | | |
|  | | | | | | | | | |
| **Avoid delays in processing:**  Management and monitoring plan attached  Consultant support attached, if applicable  Other S8 medicines management plan, if applicable  TGA approval, if applicable | | | | | | Ensure all details are completed and all required documentation is attached. | | | |

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| 1. **Application declaration** | | | |
| I declare the information provided in this application is true and correct to the best of my knowledge. I will prescribe in accordance with the Schedule 8 Medicines Prescribing Code and any authorisation issued by the Chief Executive Officer of the Department of Health. | | | |
| Prescriber’s signature: |  | Date: |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Office Use Only** | | | | | | |
| **History** | **Processing** | | | | | |
| Rx = appn: Y / N | Auth: Y / N | Drug | Dose and frequency | Auth #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Current authorisations: | Dr 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Conditions:   S8C   ↓ | | |
| S8  Stim  CPOP | Dr 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | ↓ to 0  LD \_\_\_\_\_\_\_\_\_ | | |
|  | Letter ref: \_\_\_\_\_\_\_ |  | | Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | harm: | | \_\_\_\_\_\_ | Date: | \_\_\_\_\_ |