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| **Important information:**  Notification pathway is only applicable to Approved Prescribers for prescribing which meets the general conditions of notification as per the *Schedule 8 Medicines Prescribing Code*. Refer to the *Schedule 8 Medicines Prescribing Code* for further information. Contact the Schedule 8 Prescriber Information Service (9222 4424) to obtain a Schedule 8 prescribing history. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Notification type** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| New | | | | Change in patient detail | | | | | | | | | Change in co-prescriber | | | | | | | | | | | | Change in product | | | | | | | | | |
| Termination of treatment, reason: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Patient details** Patient must be over 18 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | | |  | | | | | | | | | Surname: | | | |  | | | | | | | | | | | DOB: | | |  | | | | |
| Address: | | |  | | | | | | | | | | | | | | | Suburb: | | |  | | | | | | | Postcode: | | | |  | | |
| Aliases: |  | | | | | | | | | | | | | Gender: | | | | | | Male | | | | Female | | | | | Unspecified | | | | | |
| Is this person of Aboriginal or Torres Strait Islander origin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | Yes, Aboriginal | | | | | | | Yes, Torres Strait Islander | | | | | | | | | | | | Both Aboriginal & Torres Strait Islander | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Condition requiring treatment** | | | | | | | | | | | Condition must be consistent with TGA approved indication for product or as approved by the CEO of Department of Health. | | | | | | | | | | | | | | | | | | | | | | | |
| Multiple Sclerosis | | | | | | Other, please specify | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Treatment risk factors** Authorisation must be sought if the answer is Yes to either of the following questions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the patient have a history of substance abuse, doctor shopping or diversion within the previous five years or is the patient a Drug Dependent or Oversupplied Person? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | No |
| Does the patient have a history of psychosis or another serious psychiatric comorbidity? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | No |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Treatment details** Product must be TGA registered or otherwise compliant with Therapeutic Goods Order 93 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Product | | | | | | | | Strength | | | | | | | | | Formulation | | | | | | | | | Dose and Frequency | | | | | | | | |
|  | | | | | | | |  | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Approved prescriber details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name: | | | | |  | | | | | | | | | | | | | | Surname: | | | |  | | | | | | | | | | | |
| Prescriber or AHPRA number: | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Practice name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | Suburb: | | | | | | |  | | | | | | | Postcode: | | | |  | |
| Telephone | | | | |  | | Fax: | | |  | | | | | Practice email: | | | | | | |  | | | | | | | | | | | | |

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| 1. **Co-prescriber details** | | | | | | |
| First Name: | |  | | Surname: | |  |
| Practice name: | |  | | | | |
|  | | | | | | |
| 1. **Applicant declaration** | | | | | | |
| I hereby notify the Chief Executive Officer of Health of treatment with Cannabis-Based Products in accordance with the *Schedule 8 Medicines Prescribing Code.* I declare that information provided in this application is true and correct to the best of my knowledge. I confirm that that I have made the patient or parent/guardian (where applicable) aware that information included on this form will be forwarded to the Department of Health. | | | | | | |
| Signature: |  | | Date: | |  | |