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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)
 |
|  |
| 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)  |
|       |
|       |
|  |
| 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**
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| 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: | \_\_\_\_\_ |