Government of **Western Australia**
Department of **Health**
Public and Aboriginal Health Division

Application to prescribe opioid substitution treatment Community Program for Opioid Pharmacotherapy (CPOP)

NOTE: Please ensure all details are completed to avoid delays in progression of the application.

1. Application type

☐ New patient ☐ New prescriber ☐ Re-engaging with treatment ☐ Change in treatment

☐ Addition of Co-prescriber (Note: only to be completed by a Next Step Specialist Prescriber)

2. Patient details

First name: _____ Surname: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Aliases: _____

Gender ☐ Male ☐ Female ☐ Unspecified Medicare no.: _____ ☐ Copy of endorsed ID to CPP

Patient identification - number of documents sighted (refer to WA CPOP policies and procedures)

Category A _____ Category B _____ Category C _____

Is this person of Aboriginal or Torres Strait Islander origin:

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

Is this patient a health professional with access to Schedule 8 medicines? ☐ Yes ☐ No

3. Current treatment details

Is the patient receiving treatment from another CPOP prescriber? ☐ No ☐ Yes Name of prescriber: _____

Current pharmacotherapy: ☐ methadone ☐ buprenorphine SL ☐ buprenorphine SC

Anticipated last dose (mg): _____ Date of anticipated last dose: _____

Is the patient transferring to new pharmacy? ☐ Yes ☐ No Current pharmacy: _____

4. Proposed treatment details

☐ Patient Contract to Receive Opioid Substitution Treatment completed and signed

a. ☐ Methadone* Proposed start date: _____

Dose (mg) day 1: _____ Day 2: _____ Day 3: _____ Day 7: _____

*the starting dose of methadone should be ≤25 mg with a maximum dose of ≤ 30-40 mg at the end of the first week.

b. ☐ Suboxone® **OR** ☐ Subutex® Proposed start date: _____

Dose (mg) Day 1: _____ Day 3: _____ Reason for Subutex®: _____

c. ☐ Buvidal® SC **OR** ☐ Sublocade® SC Proposed start date: _____

i ☐ Buvidal® SC First dose: _____ mg ☐ Weekly ☐ Monthly

ii ☐ Sublocade® SC*: Dose 1: _____ mg Dose 2: _____ mg Maintenance dose: _____ mg

*Please refer to the Clinical Guidelines for Depot Buprenorphine and the Sublocade® Product Information for guidance and instructions on recommended dosing and administration.

5. Other treatment details

a. Has the patient previously been treated with methadone or buprenorphine? ☐ Yes ☐ No

b. Is the patient also taking prescribed or illicit benzodiazepines?

☐ Yes, please specify name and total daily doses: _____ ☐ No

c. Consider a baseline ECG prior to commencement of OST. Special precautions should be noted for patients receiving methadone alongside other medication known to cause QT prolongation. Caution should be used when there is concomitant use of sedatives or psychiatric medication.

Please complete both pages

Patient name: _____ **DOB:** _____

6. Pharmacy details

Name: _____ Is pharmacy open 7 days: ☐ Yes ☐ No

Telephone: _____ Fax: _____

Secondary pharmacy or depot buprenorphine pharmacy (if applicable): _____

Telephone: _____ Fax: _____

7. Drug use details

Is the patient assessed as currently physically dependent on opioids? ☐ Yes ☐ No

If no, what is the reason for induction: _____

Opioid(s) being used: _____

Duration of current use: _____

8. Patient acknowledgement

I am aware that my health practitioner must provide my name and related information included in this form to the Department of Health as I have been assessed as being eligible for inclusion on the Drugs of Addiction Record (the Record). I am aware that the information relating to me on the Record will only be provided to my treating practitioner to assist with my medical treatment with drugs of addiction. I am aware that before a drug of addiction is prescribed for me, my health practitioner must seek prior approval from the Department to do so. This will not affect my access to emergency treatment with these medicines. My information is confidential and will only be exchanged between officers of the Department of Health, Next Step Drug and Alcohol Services, prescribers, pharmacists and other health workers involved in managing my treatment and for monitoring, evaluation and approved research purposes. I am aware that admission to this program will involve treatment with a drug that may cause dependence.

Signature: _____ Date: _____

Patient name: _____

9. Prescriber details

First name: _____ Surname: _____

Practice name: _____ Contact: _____

Prescriber number: _____

Co-Prescriber name (only to be completed by a Next Step specialist prescriber only: _____

Practice name: _____ Contact : _____

10. Prescriber declaration

This application is made in accordance with the *Monitored Medicines Prescribing Code* and *Western Australian Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*. The information provided in this application is true and correct to the best of my knowledge. I have provided this patient with printed information regarding the pharmacotherapy, WA program requirements and *Patient Information: Reporting Drug Dependent Persons.* Risks of overdose during the induction period have been clearly explained and discussed with the patient.

Signature: _____ Date: _____

CPP Use Only:

Treatment plan complies with WA CPOP policies and procedures: ☐ Yes ☐ No

Signature: _____ Date: _____