Queensland Government

Queensland Health
Medicines and Poisons Act 2019

MPA-75,78,&82:PAMM
Version 3 - 04/2024

Initial, amendment or renewal application for a prescribing approval for (Schedule 8) psychostimulants under the *Medicines and Poisons Act 2019*

Privacy statement – please read carefully

Personal information collected by Queensland Health is handled in accordance with the *Information Privacy Act 2009*. Queensland Health is collecting your personal information with your consent for the purpose of deciding an application under the *Medicines and Poisons Act 2019*, including by ensuringthat health risks arising from the use of regulated substances. are appropriately managed. All personal information will be securely stored and only accessible by Queensland Health. Your personal information will not be disclosed to any other third parties without consent unless the disclosure is authorised or required by law. For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.qld.gov.au/global/privacy.

PLEASE CHECK QSCRIPT TO VIEW THE OUTCOME OF YOUR APPLICATION

Application type

Initial application for prescribing approval to treat a patient with Schedule 8 psychostimulant medicine		☐
Application to **amend** an approval to treat a patient with Schedule 8 psychostimulant medicine **Please provide details of amendment in Section 7**	Approval number	☐
Application to **renew** an approval to treat a patient with Schedule 8 psychostimulant medicine	Approval number	☐

Section 1 – Prescriber details (applicant)

Provide details of the person seeking the prescribing approval

Title		Given name/s		Surname	
Occupation		AHPRA Registration No			
Practice name					
Practice address					
Town/Suburb		State		P/C	
Work phone		Mobile phone			
Work email address					

Do you have any restrictions on your professional registration (e.g. conditions or undertakings) that would prevent you from prescribing the medicines you are applying for a prescribing approval for?	☐ Yes	☐ No

If yes, provide further details of the restrictions on your professional registration:

Section 2 – Patient details

Provide details of the patient: *Please provide given name and surname as per* ***medicare card***

Title		Given name/s		Surname	

Alternative identities: *Please provide details of any alternative (previous or current) identities/names used by the patient*

Gender	Male ☐	Female ☐	Other		DOB		
Street address							
Town/Suburb		State		P/C			

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Section 3 – Diagnosis for treatment with Schedule 8 psychostimulant medicines

☐	Attention Deficit Disorder — Adult (ADD/ADHD)	
☐	Attention Deficit Disorder — Child (ADD/ADHD < 4 years)	
☐	Attention Deficit Disorder — Child (ADD/ADHD >4 years and <18 years) **NOTE – approval not required for medical practitioners prescribing within dosage limits**	
☐	Idiopathic hypersomnolence (not including narcolepsy)	
☐	Binge eating disorder (lisdexamfetamine only)	
☐	Treatment resistant depression	
☐	Palliative care	
☐	Other:	(Please provide evidence of diagnosis, and treatment plan made by supporting specialist)

Section 4 – S8 psychostimulant medicine proposed to be prescribed under this approval

☐	Dexamfetamine	Daily Dose:	mg/day
☐	Lisdexamfetamine	Daily Dose:	mg/day
☐	Methylphenidate	Daily Dose:	mg/day

Section 5 – Supporting specialist details – S8 psychostimulant treatment

Please provide details of the relevant specialist that made the diagnosis in Section 3 AND the treatment proposed in Section 4.

Include letter of referral from relevant specialist supporting diagnosis and treatment plan.

- **For applications to treat an adult (≥ 18 years) with ADD/ADHD, the relevant specialist is a psychiatrist**
- **For applications to treat a child with ADD/ADHD the relevant specialist is a paediatrician or psychiatrist**

Title		Given name/s		Surname	
Medical specialty		AHPRA Registration No			
Work phone		Work email address			
Name of location where specialist practices:		Date of last review by relevant specialist			
Street Address					
Town /Suburb		State		P/C	
I confirm that I am applying to prescribe the medicine(s) in Section 4 in accordance with a treatment plan for the patient named in the application, **made by the specialist** named above.				☐	

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Section 6 – Duration of the prescribing approval (s.69 MPA)

Please specify the requested term for the prescribing approval. Applicants should note that prescribing approvals will not usually be granted for more than two (2) years.

Please specify the term for the prescribing approval being sought:

☐	2 years	Another term or end date, please specify:	

Section 7 – Additional information and attachments

Provide any additional information to support your application (e.g. if applying to amend a prescribing approval, detail what you are seeking to have amended).

Section 8 – Consent and Declaration

By making this application:

☐	I consent to Queensland Health collecting, using and disclosing my personal information for the purpose of determining this application and any matters relevant to this prescribing approval
☐	I consent to Queensland Health making enquiries of, and exchanging information with, the authorities of any Australian state or territory, or of the Commonwealth, regarding any matters relevant to this application (which may include a criminal history check). If relevant information cannot be obtained from other entities, Queensland Health will determine the application on the information available.
☐	I declare that, to the best of my knowledge, all information provided in and with this application form is true and correct in every detail.
☐	I understand that if anything has been stated in this application form, or in an attachment provided with this application, that is false or misleading, any substance authority granted may be suspended or cancelled.

Signature	Full name	Date

APPLICATIONS FOR ALL NON-QOTP PRESCRIBING APPROVALS CAN BE SUBMITTED TO:

The Chief Executive, Queensland Health
c/ o Medicines Approvals and Regulation Unit (MARU)
medicines.applications@health.qld.gov.au

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CLEAR FORM