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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**
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| 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: |       |