# APPLICATION FOR APPROVAL TO PRESCRIBE MEDICINAL CANNABIS

Medicines Poisons and Therapeutic Goods Regulation 2008

**ALL DETAILS MUST BE COMPLETED AND ALL DETAILS MUST BE LEGIBLE OR CONSIDERATION OF THIS APPLICATION MAY BE DELAYED.**

**FAX to: 02 6205 0997** **Please tick if application is URGENT ☐**

## SECTION A: PRESCRIBER DETAILS

| | | |
|---|---|---|
| ***Name:*** | ***AHPRA Speciality:*** | ***AHPRA Registration Number:*** |
| ***Practice Name:*** | ***Phone:*** | ***Fax:*** |
| ***Practice Address:*** | ***Email:*** | |

## SECTION B: PATIENT DETAILS

| | | |
|---|---|---|
| ***Name:*** | ***Date of Birth:*** ____/____/____ | ***Sex:*** ☐ M ☐ F ☐ x |
| ***Address:*** | | |

| | |
|---|---|
| **DIAGNOSIS:** | |
| **INDICATION FOR CANNABIS:** | |
| **PROPOSED DOSE:** | |
| **EXPECTED MAXIMUM DOSE:** | |
| **ROUTE OF DELIVERY** | ☐ **VAPORISED**<br>☐ **ORAL LIQUID**<br>☐ **SPRAY**<br>☐ **OTHER (please specify)**_____ |
| **IS A MEDICAL DEVICE TO BE USED IN DELIVERY?:** | ☐ **NO**<br>☐ **YES (please specify)**_____ |

## SECTION C: CATEGORY APPROVAL

☐ **CATEGORY 6A (multiple sclerosis)**

☐ **CATEGORY 6B (nausea and vomiting related to cancer chemotherapy)**

☐ **CATEGORY 6C (pain and/or anxiety in patients with active malignancy or a life limiting disease where (in either case) the prognosis might reasonably be expected to be 12 months or less)**

☐ **CATEGORY 6D (refractory paediatric epilepsy)**

**OR**

**Complete *Category Approval* or *Approval by Drug* section only**

## SECTION C: APPROVAL BY DRUG

**INDICATION:**

**COMPLETED FORMS TO BE SUBMITTED TO THE CHIEF HEALTH OFFICER**

**Phone:** 02 6205 0998 **Fax:** 02 6205 0997 **Email:** hps@act.gov.au **Post:** Locked Bag 5005, Weston Creek ACT 2611

**#Please ensure all posted applications are marked confidential.**

ACT Government Health

# APPLICATION FOR APPROVAL TO PRESCRIBE MEDICINAL CANNABIS

Medicines Poisons and Therapeutic Goods Regulation 2008

**ALL DETAILS MUST BE COMPLETED AND ALL DETAILS MUST BE LEGIBLE OR CONSIDERATION OF THIS APPLICATION MAY BE DELAYED.**

**FAX to: 02 6205 0997** **Please tick if application is URGENT ☐**

| **SECTION D: PRODUCT** | |
|---|---|
| **NAME:** | ☐ |
| **MANUFACTURER NAME:** | |
| **MANUFACTURER ADDRESS:** | |
| **PRESENTATION:** | ☐ **VAPORISED**<br>☐ **ORAL LIQUID**<br>☐ **SPRAY**<br>☐ **OTHER (please specify)**_____ |
| **COMPOSITION**<br>***(e.g. percentage composition of cannabinoids):*** | |
| **SECTION E: SPECIALIST SUPPORT FOR USE** | |
| **NAME OF SPECIALIST:** | |
| **AHPRA SPECIALTY:** | |
| **SPECIALIST HAS:** | ☐ **INITIATED CANNABIS THERAPY**<br>☐ **PROVIDED WRITTEN OR VERBAL OPINION SUPPORTING CANNABIS THERAPY** |

## SECTION F: ATTACHMENTS (please tick):

☐ Product monograph or prescribing information from manufacturer.

☐ Authorised prescriber approval from the Therapeutic Goods Administration (TGA) (or confirmation that application has been submitted. Applications will not be approved by ACT Health until TGA approval has been obtained.

## PRESCRIBER DECLARATION (please tick):

☐ I understand that the issue of an approval does not indicate Chief Health Officer support or endorsement of a proposed treatment.

☐ My patient is aware that this product has not been registered by the Therapeutic Goods Administration and should be considered experimental.

☐ My patient is aware that driving after taking medicinal cannabis may result in a positive drug driving test.

Signature of prescriber: _____ Date: _____

## OFFICE USE ONLY

☐ Approved DAPIS Reference Number:_____ ☐ Refused

Signature:_____ Date:_____ Approval Term:___/___/_____ to ___/___/_____

**COMPLETED FORMS TO BE SUBMITTED TO THE CHIEF HEALTH OFFICER**

**Phone:** 02 6205 0998 **Fax:** 02 6205 0997 **Email:** hps@act.gov.au **Post:** Locked Bag 5005, Weston Creek ACT 2611

**#Please ensure all posted applications are marked confidential.**