



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: Month 1: _____ mg Month 2: _____ mg Month 3: _____ mg
 To commence Sublocade, patients will receive an average minimum 8mg buprenorphine daily for 7 days prior to commencement of Sublocade (*or an equivalent 16mg Weekly dose of Buvidal).

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.



Patient name: _____ **DOB:** _____

6. Pharmacy details	
Name: _____	Is pharmacy open 7 days: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, what is the reason for induction: _____	
Opioid(s) being used: _____	
Duration of current use: _____	

8. Patient acknowledgement	
<p>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.</p>	
Signature: _____	Date: _____
Patient name: _____	

9. Prescriber details	
First name: _____	Surname: _____
Practice name: _____	Contact: _____
Prescriber Number: _____	
Co-Prescriber name (Next Step Specialist prescriber only): _____	
Practice name: _____	Contact : _____

10. Prescriber declaration	
<p>This application is made in accordance with the <i>Schedule 8 Medicines Prescribing Code</i> and <i>Western Australian Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence</i>. 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 <i>Patient Information: Reporting Drug Dependent Persons</i>. Risks of overdose during the induction period have been clearly explained and discussed with the patient.</p>	
Signature: _____	Date: _____

CPP Use Only:	
Treatment plan complies with WA CPOP policies and procedures: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature: _____	Date: _____