CONFIDENTIAL

Tasmanian Government

APPLICATION FOR AUTHORITY TO PRESCRIBE KETAMINE FOR TREATMENT RESISTENT DEPRESSION FOR ADULTS (OVER 18 YEARS)

Section 59E *Poisons Act 1971*, Regulation 24 *Poisons Regulations 2018*

DETAILS MUST BE COMPLETED ***LEGIBLY*** TO PREVENT DELAY
TICK DATA AS APPROPRIATE. PLEASE USE BLOCK LETTERS

I, Dr

of:
(ADDRESS OF MEDICAL PRACTITIONER)
Postcode:

Telephone number: ( ) Fax number: ( )

apply for authority to prescribe for:

PATIENT'S NAME: **AKA**

Patient's Address:
(Full **Residential** Address)
Postcode:

Date of Birth: / / Sex: ☐ Male ☐ Female ☐ Other

Usual Occupation: Working: ☐ Yes ☐ No

Diagnosis:

Ketamine formulation and details of the manufacturer:

Dosing schedule:

Planned duration of treatment:

Patient is part of a clinical trial

☐ Yes (please attach a copy of the research protocol and HREC approval)

☐ No (please attach a copy of a second psychiatric opinion)

Previous treatments trialled:
(If space provided is insufficient, please provide information as an attachment)

Other medications and doses being concurrently prescribed:
(If space provided is insufficient, please provide information as an attachment)

Patient has received opioid pharmacotherapy as part of any treatment for opioid substance use disorder:☐ Yes ☐ No

Drug Dependency Status

And I have reason to believe that this person in the last 10 years:

☐ Has a history of drug seeking behaviour

☐ Has exhibited or Is exhibiting drug seeking behaviour

☐ Has used a notifiable or schedule 8 substances contrary to prescribing instructions and route of administration. (e.g. escalation of dose, injecting medication)

Note: A second psychiatric opinion is required if any of the above apply (please attach)

☐ None of the above is applies to this patient

☐ **Consent form and patient information attached**

Disclaimer: I acknowledge an application for approval to treat a person with Schedule 8 medication is a requirement of the *Poisons Act 1971*. I understand the granting of an authority does not in any way support or endorse the treatment I am proposing is clinically supported. I also acknowledge in making this application I am asserting this treatment is clinically appropriate and justified by my examination of the patient, and in my opinion as a registered medical practitioner.

Signature of medical practitioner: Date: / /

All correspondence to be marked "Confidential" and sent to:
Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, GPO BOX 125, Hobart TAS 7001

For further information: Tel: (03) 6166 0400, Fax: (03) 6173 0820, Email: pharmserv@health.tas.gov.au