



1. Applicant details

First name: _____ Surname: _____
 Prescriber number: _____ AHPRA Registration No: _____
 Practice name: _____
 Address: _____ Suburb: _____ Postcode: _____
 Telephone: _____ Fax: _____ Practice email: _____
 Postal address (if different to practice address):
 Address: _____ Suburb: _____ Postcode: _____
 Do you have any outstanding actions against you in relation to prescribing?
 Yes, please provide details: _____ No
 Are you subject to Medical Board of Australia supervision conditions?
 Yes, please indicate level: _____ No

2. Other practitioner details

Are other practitioners at this practice authorised CPOP prescribers? Yes No
 If yes, please provide details: _____

3. Practice details: Compliant Schedule 8 drug safe (Administration of Depot buprenorphine formulations only)

Does the practice have a compliant Schedule 8 drug safe installed? Yes No
 Refer to https://ww2.health.wa.gov.au/Articles/S_T/Storage-of-Schedule-8-medicines

4. Prescriber declaration

I agree to comply with the requirements of the Medicines and Poisons Regulations 2016, *Monitored Medicines Prescribing Code* and the *Western Australian Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence* and any conditions imposed by the Chief Executive Officer of the Department of Health.
 Signature: _____ Date: _____

Office Use Only: Community Pharmacotherapy Program

The above practitioner has satisfactorily completed CPOP training and prescriber assessment delivered by the Community Pharmacotherapy Program and is recommended for authorisation as a prescriber as follows (*tick all that apply*)

Buprenorphine formulations Co-prescriber (methadone and SL buprenorphine only)

Head of Department _____ Date: _____

Methadone (addition)

Head of Department _____ Date: _____