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| Department of Health Pharmacotherapy Dispensing Support Program |
| Tax Invoice1 |
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ABN 74 410 330 756

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| Please email invoice to: [pharmacotherapy@health.vic.gov.au](mailto:AOD.enquiries@health.vic.gov.au) | | | | | | |
| **Pharmacy Details** | | Pharmacy Name | Click or tap here to enter text. | | | |
| Address | Click or tap here to enter text. | | | ABN: | Click or tap here to enter text. | |
| Vendor No2: | Click or tap here to enter text. | |
| Phone: | (03) XXXX-XXXX | | | Bank Name: | Click or tap here to enter text. | |
| Fax: | (03) XXXX-XXXX | | | BSB Code: | XXX-XXX | |
| Email address: | Click or tap here to enter text. | | | Account Number: | | Click or tap here to enter text. |

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| Client Name: Click or tap here to enter text. | | Client DOB: Click or tap to enter a date. |
| Client reference number (CRN)3: | Click or tap here to enter text. | |



I certify that the client has been dosed with methadone and/or buprenorphine between the dates indicated

Name of pharmacist Signature: Date: Click or tap to enter a date.



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| **Notes:** | 1. A separate tax invoice must be completed for each client 2. Vendor number will be provided by the Department of Health after your first invoice 3. CRN will be provided by the Department of Health upon receipt of notification email from pharmacy 4. “Fee period” refers to the number of days the client was on the program at your pharmacy – it is strongly recommended that this invoice is provided to The Department of Health on at least a **monthly** basis. 5. GST is payable on this supply.   If you have any questions, please email [pharmacotherapy@health.vic.gov.au](mailto:aod.enquiries@health.vic.gov.au) |

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