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| Pharmacy Application for permission to supply pharmacotherapies in Victoria |
| methadone, buprenorphine, and buprenorphine/naloxone |
| OFFICIAL |

This application form is to be completed by Victorian pharmacies applying for permission to supply pharmacotherapy to eligible clients in Victoria who are living with opioid use disorder. This form may also be completed by Victorian pharmacies to inform the Victorian Department of Health (the department) about a change of pharmacy ownership, or other important details.

This form should be completed and emailed to the address specified at the end of this document. As part of the application process the pharmacist regularly and usually in charge (PRUIC) of delivering pharmacotherapy services within the pharmacy is **expected** to:

* Have read and familiarised themselves with [the Victorian policy for maintenance pharmacotherapy for opioid dependence](https://www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy/pharmacotherapy-policy-in-victoria)
* Have read and familiarised themselves with the pharmacotherapy service delivery processes outlined in the pharmacy self-directed pharmacotherapy training checklist.
* It is the PRUIC’s responsibility to ensure pharmacists and pharmacy staff are familiar with the requirements to deliver pharmacotherapy services.

It is the responsibility of the pharmacy Proprietor to ensure that each new PRUIC is made aware of the expectations outlined above, as per the Victorian Pharmacy Authority Guidelines.

Please indicate the reason for completing this application

New approval to provide pharmacotherapy services at your pharmacy

New proprietor (s) Date of ownership change: Click or tap to enter a date.

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| Previous trading name of pharmacy (if the pharmacy name is being changed) | Click here to enter pharmacy name |

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| Full name of registered pharmacist making this application | First Name Surname | |
| Full name(s) of proprietor(s) responsible for this pharmacy (if different from previous answer) | First Name Surname  First Name Surname  First Name Surname | |
| Pharmacy trading name | Click or tap here to enter pharmacy trading name | |
| Physical address of pharmacy | Click or tap here to enter physical address of pharmacy | |
| Pharmaceutical Benefits Scheme (PBS) Approval Number | Click or tap here to enter PBS Approval Number | |
| Victorian Pharmacy Authority (VPA) Licence Number | Click or tap here to enter VPA Licence Number | |
| Pharmacy telephone number | 03 XXXX XXXX | |
| Pharmacy email address | Click or tap here to enter email address | |
| Pharmacy trading hours  Monday – Friday  Saturday  Sunday | Click or tap here to enter trading hours  Click or tap here to enter trading hours  Click or tap here to enter trading hours | |
| Has the PRUIC familiarised themselves with the pharmacy self-directed pharmacotherapy training checklist [Pharmacotherapy self-assessment - pharmacists providing ORT.docx](https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/forms-and-templates/o/pharmacotherapy-self-assessment---for-pharmacists-providing-ort.docx)? | | Yes  No |
| Has the PRUIC signed and returned the pharmacy self-directed pharmacotherapy training checklist to [pharmacotherapy@health.vic.gov.au](mailto:pharmacotherapy@health.vic.gov.au)? | | Yes  No |
| The Department of Health ***strongly recommends*** that all pharmacists involved in the delivery of pharmacotherapy services complete the [Victorian Opioid Pharmacotherapy Program (VOPP)](https://www.psa.org.au/practice-support-industry/victorian-opioid-pharmacotherapy-program/) offered by the Pharmaceutical Society of Australia, funded by the Victorian Government.  If PRUIC has indicated they are unfamiliar with aspects of the checklist, the department **expects** they will attend VOPP to learn key skills required for pharmacotherapy service delivery  [You can enrol for the VOPP at the Pharmaceutical Society of Australia website.](https://www.psa.org.au/practice-support-industry/victorian-opioid-pharmacotherapy-program/) | | |
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## Declaration by applicant and proprietor(s)

I hereby declare that I have familiarised myself, with the Victorian *Policy for maintenance pharmacotherapy for opioid dependence*, and the relevant provisions of the *Drugs, Poisons and Controlled Substances Act 1981* and the Regulations made thereunder.

I also declare that I have made the *National guidelines for medication-assisted treatment of opioid dependence (April 2014)* readily available to practicing pharmacists.

If providing long-acting injectable buprenorphine (LAIB) administration services, I have familiarised myself with the requirements stipulated in LAIB addendum (2021) to the Victoria *Policy for maintenance pharmacotherapy for opioid dependence.*

If permitted to supply pharmacotherapies in Victoria, I undertake to act in accordance with those policies which the department may advise from time to time and any conditions, limitations or restrictions placed on that permission by the department.

I acknowledge that failure to provide all the information requested above may delay the processing of my application.

I give consent for the department to provide the above details collected, where appropriate, to other health service organisations supporting the delivery of pharmacotherapy services in Victoria, for the purposes of improving the delivery of pharmacotherapy services in Victoria. These include:

* The Pharmaceutical Society of Australia (PSA)
* The Royal Australian College of General Practitioners (RACGP)
* [Pharmacotherapy Area-Based Network (PABNs)](https://www.pabn.org.au/)
* [DirectLine](https://www.directline.org.au/)
* [Harm Reduction Victoria - Pharmacotherapy Advocacy Mediation & Support (PAMS)](https://www.hrvic.org.au/pams)

Additionally, I give consent for the department to provide the above details collected to those Victorian pharmaceutical wholesalers currently responsible for the supply of medications used in opioid substitution pharmacotherapy.

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| **Name of Applicant** | First Name Surname | |
| **Title/Position** | Click or tap to enter title | |
| **Signature** | | **Date** Click or tap to enter a date. |
| **Name of Proprietor** | First Name Surname | |
| **Signature** | | **Date** Click or tap to enter a date. |

*Please note that a proprietor’s signature is mandatory regardless of who has completed the application.*

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| ***Please email the completed application to:*** [pharmacotherapy@health.vic.gov.au](mailto:pharmacotherapy@health.vic.gov.au)  **For further information, please contact the Victorian Pharmacotherapy Program:** | |
| **email:** [pharmacotherapy@health.vic.gov.au](mailto:pharmacotherapy@health.vic.gov.au) |  |

## Important notice about privacy

The information collected on this form is used to assess your application for permission to supply pharmacotherapy services in Victoria against the requirements in the *Policy for maintenance pharmacotherapy for opioid dependence.*

The department collects this information so that pharmacotherapy services can be delivered in accordance with Department policy and its statutory obligations.

Further information about the Department’s privacy policy can be viewed at the [Department’s website](https://www.vic.gov.au/privacy-vicgovau). Access to the Department’s records can be requested by lodging a Freedom of Information request with the [Office of the Victorian Information Commissioner](https://ovic.vic.gov.au/freedom-of-information/for-the-public/make-your-request-online).

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