

**Instructions**

This form must be completed for all requests of medicinal cannabis to treat chronic non-cancer pain (CNCP).

Complete in **full** and provide copies of all relevant documents. The TAC cannot consider requests for medicinal cannabis without the full completion of this form. If aPain Specialist is **not** involved in the patient’s pain management or the assessment was not performed in person, we are **unable** to consider funding this request.

Refer to the TAC’s policy on [Medicinal Cannabis for the Treatment of Chronic Non-Cancer Pain](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/policies/other/medicinal-cannabis-for-the-treatment-of-chronic-non-cancer-pain-cncp-policy/). This is a sub-policy of the [TAC’s Non-Established, New or Emerging Treatments and Services policy](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/policies/other/non-established,-new-or-experimental-treatment)

Submit this form to [info@tac.vic.gov.au](mailto:info@tac.vic.gov.au) with the subject line ‘Medicinal Cannabis request for TAC Claim number \_\_\_\_\_\_\_\_\_\_’.

Section 1

## TAC client details

|  |  |  |  |
| --- | --- | --- | --- |
| First name |  | Last name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |  | Date of birth | / / |

# Section 2

## CLINICAL INDICATION

Diagnosis (es) or Medical Condition(s):

|  |  |
| --- | --- |
|  |  |

Please provide the clinical indication for the use of medicinal cannabis for treatment of CNCP related to the patient’s transport accident. Include any risk factors that should be considered.

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| --- | --- |
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Please list details of current medication and previous/current Chronic Non-Cancer Pain treatments and outcomes (e.g. pharmacological, non- pharmacological, pain medicine procedures, or surgical interventions) and provide reasons why a currently listed ARTG therapeutic product cannot be used for the treatment of this patient in this circumstance.

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# Section 3

## Multi-disciplinary involvement

The TAC requires evidence from a treating pain specialist to support the use of medicinal cannabis for treating chronic non-cancer pain.

If aPain Specialist is **not** involved in the patient’s pain management, we are **unable** to consider funding this request. Please attach Assessment from the treating pain specialist to this request.

The TAC requires a letter from the client’s GP, if they are not the prescriber, supporting the prescribing of Medicinal Cannabis for this patient

If any other specialist/s is/are also involved in the patient’s CNCP management, please provide details. Include letter of support from the patient’s addiction specialist where a patient is using oral morphine equivalent >100mg per day > than 3 months, or the patient has a history of dependency including cannabis dependency.

|  |  |
| --- | --- |
| Pain Specialist |  |
| GP |  |
| Other Specialist(s) if involved |  |

Is the patient currently using medicinal cannabis?

Yes  No

**If yes,** please provide details of product type, dose, frequency, duration, outcomes and side effects.

|  |
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|  |

# Section 4

## Treatment plan

Product details (Avoid requesting inhaled or vaporised products because of higher risk of misuse.)

|  |  |
| --- | --- |
| Category (I – V) Please select from drop-down. |  |
| Product/ Trade name (if known) | Route of administration |
| Strength (start dose to maximum trial dose) | Frequency |

Please list the outcome measure that will be used to monitor patient’s progress: Brief Pain Inventory/ Pain Self Efficacy Questionnaire/ Specific Functional Scoring/Medication reduction. Provide baseline (or current) outcome measure score.

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|  |

If this request is approved for a specific period for trial, please record the outcome measures again after this trial period. If you consider the trial effective after the trial duration (as per terms & conditions of the trial approval) please provide a written request with these measures (initial and subsequent) and details of dose and dosage form that you consider necessary for further treatment. Medication can continue until this next TAC assessment is completed. This process with outcome measures will be required on an annual basis for ongoing approval, including a reduction strategy when condition stabilizes.

***I acknowledge that-***

1. ***I have the approval to prescribe medicinal cannabis from the TGA and State or Territory Health Department.***
2. ***I have advised the patient about the risks associated with driving and operating machinery whilst using this medication. Further information for drivers regarding self-assessment of fitness to drive can be found at***[***medicinal cannabis and driving***](http://www.vicroads.vic.gov.au/safety-and-road-rules/driver-safety/drugs-and-alcohol/medicinal-cannabis-and-driving)***.***
3. ***I have advised the patient about the benefits, risks, potential complications and drug interactions associated with this medication.***

# SECTION 5

## PROVIDER DETAILS

|  |  |
| --- | --- |
| Provider name, Medicare provider number, address,  email and phone number  (Type details or insert image of  practice stamp) |  |
| TGA Permit number |  |

|  |  |
| --- | --- |
| Signature  Insert image (jpg/png) of signature.  (Or print, sign and scan the form) |  |

Icon

Description automatically generated

|  |  |
| --- | --- |
| Date | / / |

Assessment

If all of the above information is submitted, this request will be reviewed by a claims representative from the TAC and a member of the TAC’s Clinical Panel. The TAC will advise you and your client of the outcome of this request in writing. The TAC is unable to fund a patient’s medicinal cannabis prior to receiving this decision notification (including medication that has been self-funded prior to approval). If the patient is undertaking their own self-funded trial of medicinal cannabis before submitting this TAC request, outcome measures should still be provided.

Acknowledgement

I have discussed this treatment plan with my patient and I agree to discuss this plan with members of the TAC Clinical Panel as required. I understand that I can only bill the TAC for treatment that is directly related to my patient’s transport accident and that I am not able to bill for the provision of the information requested in this form.

Privacy

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law   
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)

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