College of Registered Nurses of Newfoundland & Labrador

NP Application for Extended Prescriptive Authority – Methadone for Analgesia (Pain)

Part A (Initial application)
Complete each section and initial the bottom of each page.

Section A:

_____ _____
Name CRNNL NP Licensure/Registration#

_____ _____
Phone Number Primary Email Address

_____
Address

_____ _____
Manager Name Phone Number

_____
Employer(s) Address (include site/unit)

Provide a description of your practice setting and applicability for this request:

_____

_____

Section B
Confirm you are seeking prescriptive authority for Methadone for Analgesia: ☐Yes ☐No

Section C:
Confirm access to and review of the following practice supports:

• Participate in the Provincial Prescription Monitoring Program https://www.gov.nl.ca/hcs/prescription/prescription-monitoring-program/	Yes ___ No ___
• Completed Tamper Resistant Prescription Drug Pad Program (TRPPP) education through Government of NL website and will adhere to ongoing practice requirements of the program. https://www.gov.nl.ca/hcs/prescription/hcp-tamperresistantdrugpad/	Yes ___ No ___
• Registered with the Pharmacy Network and have access to the HEALTHe NL Viewer for purposes of reviewing a patient's medication profile.	Yes ___ No ___
• Employer support for extended prescriptive authority requested above.	Yes ___ No ___
• Access to employer policies to guide practice related to prescribing Methadone and care of clients receiving Methadone for Analgesia (pain).	Yes ___ No ___
• Access to urine drug screening and/or other forms of screening as deemed appropriate for testing of drugs for possible abuse/misuse.	Yes ___ No ___
• Knowledgeable of all College of Physicians & Surgeons of NL (CPSNL) documents related to pain management (e.g. Prescribing Opioids for Acute Pain)	Yes ___ No ___

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Education and Training (attached certificates/documentation confirming your completion):

• Complete the online course Methadone for Pain in Palliative Care – available at www.methadone4pain.ca or a course/education program deemed equivalent by CRNNL.	Yes ___ No ___
• Complete the College of Physicians and Surgeons of NL (CPSNL) Introduction to Safe Prescribing: Opioids, Benzodiazepines, and Stimulants Course – available through www.mdcme.ca.	Yes ___ No ___
• Complete the Centre for Addiction & Mental Health (CAMH) Safe and Effective Use of Opioids for Chronic Non-Cancer Pain online course or a course/education program deemed equivalent by CRNNL.	Yes ___ No ___
• Attended clinical training (minimum of two days or combination of equivalent hours) with an experienced practitioner/team in the management of pain and the provision of Methadone for analgesia.	Yes ___ No ___

Nurse Practitioners seeking extended prescriptive authority must consider the following:

- Seek continuing learning opportunities for ongoing learning related to Methadone for analgesia (pain).
- NP must ensure they meet additional requirements to prescribe for analgesia (e.g. legislative or manufacturer required).
- NPs may consult with more experienced prescribers of Methadone for analgesia (e.g. pain management specialists), upon initiating treatment and/or when deemed appropriate.
- If an NP is away from the practice setting for an extended period of time, the NP must reflect on what educational requirements are needed to ensure they have the individual competence to prescribe Methadone for analgesia.

Section D:

Letters of Support (See Part B: Employer statement from your current nursing manager/supervisor confirming their support for extended prescriptive authority)

Manager/Supervisor Name: _____

Manager/Supervisor contact information: _____

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Section E: Nurse Practitioner's Declarations

I_____hereby apply for the extended prescriptive authority to prescribe Methadone for Analgesia (Pain) and declare that the information I have provided in this application is true and correct.

I_____declare that, when necessary I will consult with more experienced prescribers of Methadone for Analgesia (Pain) upon initiating treatment and/or when deemed appropriate.

I _____ declare that that I am knowledgeable of all College of Physicians and Surgeons of NL (CPSNL) documents related to pain management.

I_____understand that I may be required to complete additional educational requirements (i.e. Drug Manufacturer requirements) to prescribe for analgesia.

I_____understand that if away from the practice setting for an extended period of time I must reflect on what educational requirements are needed to ensure I maintain competence to prescribe Methadone for Analgesia.

I_____hereby give consent to the CRNNL to obtain confirmation or verification of the documentation and information submitted as part of this application, including but not limited to contacting my employer, manager or mentor.

I_____understand a link to the names of authorized prescribers will display to the CRNNL member search.

I_____declare that I have read and agree with each of the declaration statements listed above.

_____ _____

NP Signature **Date**

If you have more than one practice setting where Methadone for Analgesia is prescribed, append information for each practice setting, along with the employer and supervisor name for each practice setting. When CRNNL reviews your application, you will be notified by email when authority to prescribe Methadone for Analgesia has been granted.

For Office Use Only:

Part A: Received: _____ Part B: Received: _____ Part C: Received: _____

Part D: Received:_____ Signature:_____ Date Approved: _____

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Part C: Confirmation of Clinical Training

Please complete Section A and forward this form to the Methadone for Analgesia (Pain) provider/team who provided clinical training.

Section A: Nurse Practitioner Information

_____ _____
Surname Given Name

_____ _____ _____
Telephone Number Email Address CRNNL NP Registration/Licensure #

I hereby give consent for my employer to release the information as requested by CRNNL.

_____ _____
Date Signature of Nurse Practitioner

Section B: Statement of Methadone Provider/Team who provided Clinical Training

The above-named Nurse Practitioner has applied to CRNNL to be granted extended prescriptive authority to prescribe **Methadone for Analgesia (Pain)** in their NP practice. In accordance with CRNNL policy, an NP must complete a minimum of two days of clinical training (or a combination of equivalent hours) with an experienced Methadone provider/team prior to be granted prescriptive authority. Please complete the following statement confirming this Nurse Practitioner's completion of clinical training. Please return the completed document directly to CRNNL at registration@crnnl.ca.

On _____ the above-name nurse practitioner completed two days of
Date(s)
clinical training (or combination of equivalent hours) at _____
Location/Program
with an experienced Methadone for Analgesia (Pain) practitioner/team.

_____
Signature

_____
Position/title

_____
Date

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Part D: Confirmation of Mentor (If employed outside a Regional Health Authority)

For Nurse Practitioners (NPs) Employed with an Employer that is not a Regional Health Authority (RHA) in Newfoundland and Labrador (Includes Self Employment)

I_____, understand that it is a requirement of Council to be granted extended prescriptive authority for Methadone for Analgesia (Pain) and that I _____ have access to a mentor who has expertise in prescribing Methadone for Analgesia (Pain).

I _____ confirm that I have access to a mentor with expertise in prescribing Methadone for Analgesia (Pain).

If you are employed outside of a RHA or self-employed please provide your employer/organization name and address below.:

Name: _____

Address: _____

I _____ declare that I have policies that guide my practice in relation to prescribing Methadone and care of patients receiving Methadone for Analgesia (Pain).

I _____understand that I am required to immediately notify CRNNL should any of the information provided above change, with respect to access to a mentor.

Nurse Practitioners Signature: _____ Date: _____

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Part B: Employer Statement

Please complete Section A and forward this form to the Program Manager/Nurse Manager/Supervisor at place(s) of employment for completion.

Section A: Nurse Practitioner Information

_____ _____

Surname Given Name

_____ _____ _____

Telephone Number Email Address CRNNL NP Registration/Licensure #

I hereby give consent for my employer to release the information as requested by CRNNL.

_____ _____

Date Signature of Nurse Practitioner

Section B: Statement of Current Employer

The above-named Nurse Practitioner has applied to CRNNL to be granted extended prescriptive authority to prescribe **Methadone for Analgesia (Pain)** in their NP practice. Please complete the following statement indicating the employer's support for this nurse practitioner to prescribe **Methadone for Analgesia (Pain)**. Please return the completed document directly to CRNNL at registration@crnnl.ca.

Employer Name:_____

Employer Address:_____

Do you support this NP to prescribe Methadone for Analgesia (Pain) in their current practice setting:

☐Yes ☐No

Do you confirm that the employer has a policy(s) in place to guide the NP in their practice to prescribe Methadone and care of clients receiving Methadone for Analgesia:

☐Yes ☐ No

_____

Signature

_____

Position/Title

_____

Date