Consultation discussion paper: Prescribing by pharmacists and registered nurses

December 2025

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Introduction

Traditionally, prescribing of medicines has been limited to medical practitioners and dentists. Over the last 35 years, there has been gradual introduction of prescribing by other types of health practitioners, in Australia and in many other countries, including countries with similar regulatory frameworks to Australia such as the United States of America (USA), United Kingdom (UK), Canada and New Zealand (NZ). Prescribing by health practitioners other than medical practitioners and dentists is termed 'non-medical prescribing' and encompasses a range of prescribing models.

There are multiple drivers for the development of non-medical prescribing including benefiting patient care by effective use of health professionals' skills, improving access to timely care, increasing patient choice, reducing presentations to emergency departments, reducing hospital admissions and length of stay for admitted patients, enhancing teamwork, and better use of limited health resources. The professions themselves indicate being able to prescribe can result in increased professional recognition and respect, as well as enhanced career development.

The complexity of the overall health system in Australia, with multiple funding sources and Australia's federated government, means there are some barriers to realising the full potential of non-medical prescribing. Barriers include access to education and training, health professional remuneration, funding for prescription medicines and workplace culture.

In Western Australia (WA), the Sustainable Health Review[1] provides strategic direction for an effective and efficient WA health system. Recommendation 25 of the Review is to 'implement contemporary workforce roles and scope of practice where there is a proven record of supporting better health outcomes and sustainability'.

A 2016 Cochrane Review[2] assessed clinical, patient-reported and resource use outcomes of non-medical prescribing for managing acute and chronic health conditions in primary and secondary care settings compared with prescribing by medical practitioners (usual care). There were 26 studies involving prescribing by nurses and 20 studies where prescribing was by pharmacists. Prescribing tasks included medication initiation, dosage changes and cessation of medication and prescribing could be with, or without, guidance from established protocols and guidelines. The Review concluded that pharmacists and nurses were able to deliver comparable prescribing outcomes to medical practitioners, particularly in relation to clinical outcomes.

The Health Professionals Prescribing Pathway (HPPP)[3], developed by Health Workforce Australia, which was an initiative of the Council of Australian Governments (COAG)[4], describes three categories of prescribing:

- limited prescribing in accordance with defined protocols or from a defined formulary

[1] The final report, recommendations and implementation progress are available at: https://www.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review
[2] Available at: https://doi.org/10.1002/14651858.CD011227.pub2
[3] Health Workforce Australia, Health Professionals Prescribing Pathway (HPPP) Project – Final Report, 2013.
[4] The primary intergovernmental forum in Australia from 1992 to 2020.

- prescribing in a formal collaborative arrangement with a medical practitioner or other autonomous prescriber (sometimes termed ‘supplementary prescribing’ or ‘supervised prescribing’) and
- autonomous or independent prescribing.

The HPPP can be described as a hierarchical model, although the HPPP acknowledges that a health professional may work within more than one model of prescribing within their clinical practice. For example, the prescribing model currently used for endorsed podiatrists and endorsed optometrists is independent prescribing but from a defined formulary (list of medicines). The HPPP is intended to apply to all prescribers: medical practitioners, dentists and non-medical prescribers.

In 2012, the National Prescribing Service (NPS) published the first edition of the Prescribing Competencies Framework, which was also intended to apply to all prescribers and described the competencies required for health professionals to prescribe medicines judiciously, appropriately, safely and effectively in the Australian healthcare system. The National Prescribing Competencies Framework was recently reviewed by the Australian Health Practitioner Regulation Agency (AHPRA) and the third edition was published in September 2025[5].

Although the *Medicines and Poisons Act 2014* defines the word ‘prescribe’ as the issuing of a prescription, which includes documenting administration orders on a medication chart, this is only one step in the act of prescribing. The HPPP and the National Prescribing Competencies Framework define prescribing as being an iterative or dynamic ‘process involving the steps of information gathering, clinical decision-making, communication, and evaluation that results in the initiation, continuation or cessation of a medicine’.

Consultation purpose

This consultation is focussed on non-medical prescribing by pharmacists and registered nurses and amendments to the Medicines and Poisons Regulations 2016 (the Regulations) to support this. In particular, the consultation is concerned with the constraints required to appropriately manage risks to patients and the broader public, that may be associated with these classes of registered health practitioner issuing prescriptions. The proposed regulatory models may also be suitable for other future non-medical prescriber classes, such as physiotherapists and paramedics.

Other aspects of issuing prescriptions, such as information that must be included on a prescription and prescription formats, including prescriptions issued electronically, are already included in the Regulations and are applicable to any authorised prescriber.

The funding of prescription medicines, such as via the Pharmaceutical Benefits Scheme (PBS), is outside the scope of this consultation.

Pharmacists

Over the last few years, various pharmacist prescribing trials and programs have emerged across Australia and, in WA, there are two programs under development, which can only proceed if pharmacists are authorised to prescribe.

[5] https://www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/National-Prescribing-Competencies-Framework.aspx

In August 2024, the WA government committed to an expanded role for community pharmacists.[6] It is intended this pilot program will allow community pharmacists to prescribe medicines to patients for a specific range of health conditions. Further detail about the Enhanced Access Community Pharmacy Pilot (EACPP) is available on the WA Health website at: https://www.health.wa.gov.au/Articles/A_E/Enhanced-Access-Community-Pharmacy-Pilot.

In WA Health public hospitals, pharmacists have been writing up orders on medication charts for some years, but the current regulations require a prescriber to sign off on each of these orders before doses can be administered to patients. There is support from the executives of the various health service providers[7], via the WA Health Executive Committee, for pharmacists, with demonstrated competency, to be able to sign off on medication chart orders, particularly in relation to orders for ongoing medications at admission and standardised regimes at pre-admission clinics, such as may be used in certain types of elective surgery. In this prescribing model, pharmacists would be prescribing in a prescribing agreement with the medical team responsible for the patient.

Registered nurses

The Nursing and Midwifery Board of Australia (NMBA) has undertaken public consultation on an endorsement for registered nurses to prescribe in a formal prescribing agreement with an autonomous prescriber, such as a medical practitioner or nurse practitioner. The NMBA's Decision Regulation Impact Statement: Registration Standard: Endorsement for scheduled medicines – designated registered nurse prescriber was published on 19 December 2024 and is available online at: https://oia.pmc.gov.au/published-impact-analyses-and-reports/expanded-role-registered-nurses-improve-access-healthcare.

At their December 2024 meeting, health ministers from across Australia approved the new registration standard to allow designation of registered nurse prescribers[8]. The NMBA registration standard and accompanying guidelines came into effect on 30 September 2025[9].

Endorsement as a designated registered nurse prescriber means the NMBA considers these nurses to be *qualified* to administer, obtain, possess, prescribe, supply and/or use medicines in Schedules 2, 3, 4 and 8, in partnership with an authorised health practitioner, under a prescribing agreement.

As for all non-medical health practitioners holding an endorsement for scheduled medicines, before these health practitioner classes can issue prescriptions in WA, they must hold *authority* to prescribe under the Medicines and Poisons legislation.

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[6] https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/New-expanded-role-for-community-pharmacies-introduced-in-WA-20240809

[7] Health service providers: Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service.

[8] Health Ministers' Meeting Communique 6 December 2024. Available at: https://www.health.gov.au/resources/publications/health-ministers-meeting-hmm-communique-6-december-2024?language=en

[9] https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-designated-RN-prescriber.aspx

Current regulatory framework for prescribing

In WA, the regulatory framework for authorising health practitioners to issue prescriptions for certain types of medicines is through the *Medicines and Poisons Act 2014* (the Act) and the subsidiary Medicines and Poisons Regulations 2016 (the Regulations). Section 25 of the Act provides for the making of regulations that give a defined class of health professional authority to administer, possess, prescribe, supply and/or use a medicine.

The Act and Regulations are only applicable to 'scheduled' medicines. These are medicines included in the 'schedules' of the national Poisons Standard[10] and are defined as follows:

Table 1: Medicines schedules

Schedule	Label heading	Definition	Examples
2	Pharmacy medicine	Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.	Antihistamine Small packs of anti-inflammatory analgesics such as diclofenac and naproxen Paracetamol products for children
3	Pharmacist only medicine	Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.	Emergency contraceptive pill Chloramphenicol eye drops Salbutamol inhalers
4	Prescription only medicine	Substances, the use or supply of which should be by or on the order of persons permitted under the Act to prescribe and should be available from a pharmacist on prescription.	Antibiotics Antihypertensives Antidepressants Cholesterol lowering medicines
8	Controlled drug	Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.	Oxycodone Tapentadol Dexamfetamine

[10] The Poisons Standard is available via the Commonwealth Therapeutic Goods Administration website at: https://www.tga.gov.au/how-we-regulate/ingredients-and-scheduling-medicines-and-chemicals/poisons-standard-and-scheduling-medicines-and-chemicals/poisons-standard-susmp.

Current professional authorities for pharmacists and registered nurses

Under the Regulations, authorities for pharmacists and registered nurses, who are not also nurse practitioners, in relation to Schedule 4 (S4, prescription only) and Schedule 8 (S8, controlled drugs) medicines are shown in the following table.

Table 2: Professional authorities for Schedule 4 and Schedule 8 medicines

Health practitioner	Possess	Administer	Supply^	Dispense	Prescribe
Pharmacist	✓	✓	✓	✓	×
Registered nurse[#]	✓	✓	✓*	×	×

[^]Structured Administration and Supply Arrangement (SASA) required

[#]Who is not a nurse practitioner

*Schedule 4 only

Pharmacists can dispense medicines in S4 and S8 once they have received a prescription issued by a health professional with prescribing rights. Similarly, in the hospital setting, doses of S4 and S8 medicines can be administered to patients once an authorised prescriber has written or approved an order on a medication chart.

In the Act and Regulations, the term ‘dispense’ relates to the act of supply following receipt of a prescription. The legislation does not consider direct supply to a patient, by the prescribing health practitioner, as ‘dispensing’. Only pharmacists are authorised to ‘dispense’.

Pharmacists can only independently initiate administration or supply of a S4 or S8 medicine to a patient where there is a Structured Administration and Supply Arrangement (SASA) in place. Similarly, registered nurses can only initiate administration of a S4 or S8 medicine or supply of a S4 medicine under a SASA.

SASAs can only be issued for acute care or for public health programs, such as vaccination. Department of Health issued SASAs include SASAs which authorise:

- Pharmacists to:
    - administer doses of vaccines on the WA Immunisation Schedule
    - supply a patient with a short course of specific antibiotics for the treatment of uncomplicated urinary tract infections
- Registered nurses to:
    - administer doses of vaccines on the WA Immunisation Schedule
    - supply certain S4 medicines, from remote area nursing services, for the treatment of defined acute health conditions.

SASAs cannot be used to authorise a health professional to issue a prescription, for dispensing by a pharmacist.

Pharmacists are authorised to independently supply medicines in Schedule 2 (S2, pharmacy medicine) and Schedule 3 (S3, pharmacist only medicine). Registered nurses can only supply S2 and S3 medicines where a relevant SASA exists and at certain remote medical clinics, where no community pharmacy service is available.

For some classes of health practitioner, endorsement of individual practitioners for scheduled medicines, via their respective national Board, indicates the health practitioner is considered

qualified to prescribe the medicines for which they hold endorsement. For each class of health practitioner currently holding this type of endorsement, the Regulations provide the *authority* for these health practitioners to prescribe in line with their endorsement.

In October 2019, the Pharmacy Board of Australia issued a position statement on pharmacist prescribing[11]. The Board considered there were no regulatory barriers, in terms of the registration of pharmacists, to prescribe via structured prescribing arrangements or under supervision within a collaborative healthcare environment. However, the Board acknowledged that prescribing under these models would require changes in state and territory medicines and poisons legislation to authorise pharmacists to prescribe. The Board also stated their view was that autonomous prescribing would require additional regulation, under the Health Practitioner National Law, via an endorsement for scheduled medicines.

In other words, the Pharmacy Board is of the opinion that pharmacists are already suitably qualified to undertake all except fully independent prescribing.

On 17 September 2025, the Pharmacy Board issued a media release stating that they had begun work to establish an endorsement for scheduled medicines for pharmacists, to support a consistent, safe, and nationally coordinated approach to pharmacist prescribing[12].

The Pharmacy Board funded the Australian Pharmacy Council, the accrediting authority for pharmacy education programs, to develop accreditation standards to educate pharmacists to be able to prescribe independently. These standards, which will apply to pharmacist prescriber education programs, were released in December 2023[13] and are intended to ensure graduates of any accredited education program meet the competencies of the national Prescribing Competencies Framework.

Current non-medical prescribing in Western Australia

The Regulations currently include authority for nurse practitioners, endorsed podiatrists, endorsed optometrists and endorsed midwives to prescribe. All these types of health practitioner have an ‘endorsement’ on their registration, as a health practitioner, indicating they are considered *qualified* to prescribe. Their prescribing *authority* under the Regulations aligns with the endorsement on their registration and in all cases is limited to prescribing ‘in the lawful practice of their profession’.

Currently, both endorsed podiatrists and endorsed optometrists can only prescribe from a defined list of medicines developed by their respective registration Boards.

Nurse practitioners and endorsed midwives do not have a specific formulary and prescribe within their profession-related, and personal, scope of practice.

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[11] Available at: https://www.pharmacyboard.gov.au/news/professional-practice-issues/pharmacist-prescribing-position-statement.aspx
[12] Available at: https://www.pharmacyboard.gov.au/News/2025-09-17-Endorsement-for-scheduled-medicines.aspx
[13] Available at: https://www.pharmacycouncil.org.au/resources/Accreditation-Standards-for-Pharmacist-Prescriber-education-programs/

Prescribing by registered nurses

International experience

The international experience of nurse prescribing is detailed in the May 2024 NMBA Decision regulation impact statement relating to the registration standard on endorsement for scheduled medicines for designated registered nurse prescribers.[14] Prescribing by nurses, using a variety of prescribing models, is now well established in many countries and the NMBA paper presents evidence that nurses can prescribe safely and effectively.

In the UK, which has similar regulatory controls over medicines to Australia, various forms of nurse prescribing have been in place since 1992. Initially nurses were limited by a formulary and by their work setting. Community nurses, such as district nurses and school nurses, continue to prescribe independently but from a limited formulary. Since 2006, other independent nurse prescribers have been able to prescribe any licensed medicine for any medical condition within their clinical competence. Prescribing of controlled drugs (equivalent to S8 medicines) by independent nurse prescribers was introduced in 2012.[15] Supplementary nurse prescribing, which is equivalent to collaborative prescribing, is also used in the UK, where the nurse must be in a prescribing partnership with a medical practitioner.

In NZ, certain nurses, who are working in primary health and specialty teams have been able to independently prescribe since 2016[16]. Designated nurse prescribers must prescribe from a list of medicines (formulary) determined by the NZ Department of Health. The list[17] does not, at present, include any drugs that would be classified as S8 medicines in Australia. An exception to this is collaborative prescribing within structured opioid substitution therapy programs[18].

Regulatory options for prescribing and supply of Schedule 4 and Schedule 8 medicines

Designated registered nurse prescribers will be endorsed for scheduled medicines by the NMBA, which means the NMBA considers these registered nurses qualified to prescribe these medicines, including having completed approved training and having the equivalent of at least three years full-time clinical experience (5000 hours) in the six years preceding application for endorsement.

Unlike all other current health practitioner endorsements for scheduled medicines, where endorsed health practitioners are considered qualified to prescribe independently, the NMBA Registration Standard limits designated registered nurse prescriber endorsement to collaborative prescribing. The designated registered nurse prescriber must have a formal prescribing agreement with a health practitioner with independent prescribing rights and the prescribing agreement must be approved by the relevant health organisation/service or employer.

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[14] Available at: https://oia.pmc.gov.au/published-impact-analyses-and-reports/expanded-role-registered-nurses-improve-access-healthcare
[15] See https://www.health-ni.gov.uk/articles/prescribing-non-medical-healthcare-professionals
[16] See
[17] Available at: https://gazette.govt.nz/notice/id/2024-go3984
[18] Available at: https://www.health.govt.nz/publications/prescribing-controlled-drugs-in-addiction-treatment-2018-guidance-for-nurse-practitioners-designated

The expectation is that the governance framework used by the approving health organisation/service or employer, to enable prescribing agreements, would include an assessment for prescribing of high-risk medicines, including but not limited to, S8 medicines and chemotherapy agents.

Regardless of any requirements of the designated registered nurse prescriber's prescribing agreement, compliance with other parts of the Act and Regulations in relation to prescribing would be mandatory. For example, prescribing of S4 monitored medicines and S8 medicines would need to be in accordance with the Monitored Medicines Prescribing Code[19].

Currently, a barrier exists to designated registered nurse prescribers from accessing ScriptCheckWA, WA's real time prescription monitoring (RTPM) system. Until such time as this class of prescriber has access to ScriptCheckWA, consideration should be given to the safety of these prescribers issuing prescriptions for monitored medicines, in circumstances where the medicines will be directly supplied or dispensed to the patient. These are the circumstances where the highest risks of overdose harm and diversion exist and where ScriptCheckWA provides valuable information to clinicians to allow informed prescribing decisions. It may be acceptable for the designated registered nurse prescriber to prescribe monitored medicines in settings where the patient does not have full responsibility for their medicines, such as for hospital inpatients and for people in residential care facilities and custodial settings.

All states and territories, including WA, are working with the national RTPM vendor, with a view to enhancing the jurisdictional RTPM systems to allow access for designated registered nurse prescribers.

Prescribing of Schedule 4 and Schedule 8 medicines

Regulatory Option 1: No change, designated registered nurse prescribers are not authorised to prescribe in WA (status quo).

Regulatory Option 2: Authorise in a similar way as other health practitioner classes who hold an endorsement for scheduled medicines, by allowing designated registered nurse prescribers to prescribe in line with the requirements of the *NMBA Guidelines for registered nurses applying for and with the endorsement for scheduled medicines – designated registered nurse prescriber*[20]

Regulatory Option 3: Authorise designated registered nurse prescribers to prescribe but detail specific requirements within the Regulations as well as compliance with the *NMBA Guidelines for registered nurses applying for and with the endorsement for scheduled medicines – designated registered nurse prescriber*.

Proposed specific requirements include:

- There is a current written prescribing agreement signed by both the authorising prescriber and the designated registered nurse prescriber.
- The authorising prescriber and the designated registered nurse prescriber are employed by or contracted to, the same health organisation/service or employer.

[19] Available at: https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Medicines-and-Poisons/PDF/Monitored-Medicines-Prescribing-Code.pdf
[20] Available at: https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-designated-RN-prescriber.aspx

- The current written prescribing agreement is approved by the employing/contracting health organisation/service or employer.
- The written prescribing agreement is reviewed at regular intervals, such as every 12 months or every 2 years, by both the authorising prescriber and the designated registered nurse prescriber and after review, must be re-approved by the employing/contracting health organisation/service or employer.
- Any changes (not in conjunction with a review) to the written prescribing agreement must be agreed by both the authorising prescriber and the designated registered nurse prescriber and approved by the employing/contracting health organisation/service or employer.
- If the authorising prescriber or the designated registered nurse prescriber is no longer employed by or contracted to, the approving health organisation or employer, the agreement is no longer considered current and cannot be used to authorise prescribing by the designated registered nurse prescriber.
- Require all prescribing of S8 medicines, as well as S4 medicines monitored through ScriptCheckWA[21], by designated registered nurse prescribers to be compliant with the requirements of Part 11 of the Regulations. Compliance with Part 11 of the Regulations includes adhering to the Monitored Medicines Prescribing Code. This requirement is already in place for all other health practitioners with authority to prescribe S8 and S4 monitored medicines.

Another safety consideration is which autonomous prescribers should be authorised to form a prescribing arrangement with a designated registered nurse prescriber. The NMBA's Registration Standard and the Guidelines do not limit which type of autonomous prescriber can enter into a prescribing arrangement with a designated registered nurse prescriber. The examples of autonomous prescribers included in the NMBA Guidelines are medical practitioners and nurse practitioners.

The NMBA documents include requirements for the authorising autonomous prescriber to ensure their scope and area of practice align with the designated registered nurse prescriber's scope of prescribing. A prescribing agreement could not allow the registered nurse to prescribe a medicine that the autonomous prescriber was not authorised to prescribe.

Regulatory Option 4: Authorise designated registered nurse prescribers to prescribe and require that prescribing to be in accordance with a 'prescribing instrument'. This the preferred option, as a prescribing instrument can be more responsive to the development of designated registered nurse prescribing, as this new practice matures over time.

In line with other approvals under the Act and Regulations, a prescribing instrument would be approved by the Chief Executive Officer of the Department of Health (CEO) or their delegate.

The prescribing instrument would include the same type of requirements as Regulatory Option 3. As a regulatory instrument, a 'prescribing instrument' could only include requirements considered essential for ensuring safe prescribing.

Any prescribing instrument would be published on the Department's website.

Advantages and disadvantages of each Regulatory Option are shown in the following table:

[21] ScriptCheckWA is the Western Australian real-time prescription monitoring system.

Table 3: Advantages and disadvantages of Regulatory Options

Option	Advantages	Disadvantages
Option 1: No authorisation to prescribe (Status quo)	No change.	When working in WA, designated registered nurse prescribers will not be able to work at the scope level for which they are qualified. Lack of alignment with other states and territories. Potential benefits from prescribing by designated registered nurse prescribers cannot be realised.
Option 2: Refer to NMBA Guidelines	Option used to authorise other endorsed prescribers. Future changes to NMBA Guidelines automatically incorporated.	NMBA may change Guidelines without notification.
Option 3: Include specific requirements in Regulations	Clearly indicates when a prescribing agreement is/is not valid and this is unaffected by future changes to the NMBA Guidelines.	Limited flexibility to accommodate changes in prescribing practice – future regulatory amendment likely to be required. Lack of alignment with NMBA Guidelines may occur over time.
Option 4: Include specific requirements in a 'prescribing instrument'	Clearly indicates when a prescribing agreement is/is not valid and this is unaffected by future changes to the NMBA Guidelines. Greater flexibility to accommodate changes in prescribing practice.	Could potentially be used to introduce barriers to prescribing that extend beyond ensuring protection of public health. Preferred option.

1. Consultation questions: Regulatory Options for prescribing of Schedule 4 and Schedule 8 medicines by designated registered nurse prescribers

1.1 Which Regulatory Option do you support for prescribing by designated registered nurse prescribers?

Please select ONE option

☐ Option 1: Do not authorise prescribing (status quo)	☐ Option 2: Authorise prescribing and refer to NMBA Guidelines	☐ Option 3: Authorise prescribing and include requirements in Regulations	☐ Option 4: Authorise prescribing and include requirements in a mandatory 'prescribing instrument'	☐ None of the options are suitable	☐ Unable to comment

1.2 If you supported Regulatory Option 3 or Regulatory Option 4, please comment on whether any of the suggested specific requirements should be modified or removed, and what modification should be made:

1.3 If you supported Regulatory Option 3 or Regulatory Option 4, are there additional specific requirements (other than those listed under Regulatory Option 3) that should be included in the Regulations or in a 'prescribing instrument'?

1.4 If you selected Regulatory Option 1 Do not authorise prescribing (status quo) or selected 'none of the options are suitable', please explain why you made that selection and, if applicable, provide information on other mechanisms that could be used to authorise prescribing by designated registered nurse prescribers:

1.5 Which autonomous prescribers should be able to enter into a prescribing agreement with a designated registered nurse prescriber?

Select all that apply:

☐ Medical practitioner	☐ Nurse practitioner	☐ Dentist	☐ Endorsed midwife	☐ Endorsed podiatrist	☐ Endorsed optometrist

1.6 If you did not select all of the autonomous prescribers, please explain why you excluded certain classes of autonomous prescriber:

1.7 How supportive are you of designated registered nurse prescribers issuing prescriptions for Schedule 8 medicines (controlled drugs like morphine, oxycodone, tapentadol, dexamfetamine, methylphenidate)?

Please indicate your level of support by choosing ONE option:

☐ Very supportive	☐ Somewhat supportive	☐ Neither supportive nor unsupportive	☐ Somewhat unsupportive	☐ Very unsupportive

1.8 If you answered ‘very unsupportive’ or ‘somewhat unsupportive’ at question 1.7, please explain why you chose this option:

1.9 Please select any of the following factors that would increase your level of support for Schedule 8 prescribing by designated registered nurse prescribers (you may select as may factors as you wish):

☐ Limit Schedule 8 prescribing to oral opioids (medicines like oxycodone and tapentadol) for treatment of acute pain.

☐ Only allow designated registered nurse prescribers to prescribe up to 14 days treatment.

☐ Not allow repeats to be prescribed.

☐ Only allow prescribing in situations where no authorisation from the WA Department of Health is required. For example: no prescribing to people experiencing drug dependence, no prescribing of injectable forms (end of life care excepted), no high dose opioid prescribing.

☐ Only allow prescribing of fully TGA registered products (this means medicinal cannabis would be excluded).

☐ Not allow prescribing of stimulant medicines such as lisdexamfetamine, dexamfetamine or methylphenidate, even if the stimulant was commenced by a specialist prescriber.

☐ Only allow Schedule 8 prescribing when designated registered nurse prescribers have access to ScriptCheckWA, with the exception of prescribing for hospital inpatients and people in residential care and custodial settings.

☐ Only allow designated registered nurse prescrbers to prescribe S8 medicines for adult patients.

☐ None of the above factors would increase my support for S8 prescribing by designated registered nurse prescribers.

1.10 If there are any other factors which would increase your support for Schedule 8 prescribing by designated registered nurse prescribers, please provide details:

Supply of Schedule 4 and Schedule 8 medicines

For other health professions with prescribing rights, the Regulations allow the health professional to make a direct supply to their patient of any S4 or S8 medicine that they are authorised to prescribe. It is proposed that changes to the Regulations to allow prescribing by designated registered nurse prescribers would be accompanied by equivalent allowances for direct supply by these practitioners.

Although it is not common for prescribers to make a direct supply rather than issuing a prescription, for dispensing by a pharmacist, this may occur in situations such as: where there is no pharmacy that is readily accessible by the patient, in urgent care settings where commencement of treatment is an imperative or where a niche treatment is being prescribed. Examples include: supply from a nurse-led remote area clinic, supply for treatment of a sexually transmitted infection or supply of various medicines in anticipation of overseas travel when a person is also being administered vaccines for travel at the clinic.

All current authorised prescribers, including medical practitioners, dentists and non-medical prescribers can supply the same medicines as they are authorised to prescribe. When supplying S4 or S8 medicines, the Regulations require these prescribers to keep a detailed record of supply and label the product in a similar manner to when a prescription medicine is dispensed at a pharmacy.

The *NMBA Guidelines for registered nurses applying for and with the endorsement for scheduled medicines – designated registered nurse prescriber* indicates that separation of prescribing and supply/dispensing is preferable as it results in additional checks to safeguard patients and, additionally, harnesses the particular expertise of the pharmacist.

2. Consultation questions: Supply of Schedule 4 and Schedule 8 medicines by designated registered nurse prescribers

2.1 Should designated registered nurse prescribers be able to directly supply patients with the same S4 and S8 medicines as they can prescribe?

Please select ONE option

☐ Yes ☐ No ☐ Unsure

2.2 If you answered no, please explain why you think designated registered nurse prescribers should not be authorised to supply patients with the same S4 and S8 medicines for which they can issue a prescription:

Handling of Schedule 2 and Schedule 3 medicines

The NMBA Registration standard states that designated registered nurse prescribers are qualified to administer, obtain, possess, prescribe, supply and/or use medicines in S2, S3, S4 and S8. The Medicines and Poisons Act only requires a prescription to be issued for medicines in S4 and S8.

It would be inappropriate to require a prescription to direct pharmacists to supply a medicine in S2 or S3 because pharmacists already have a professional authority to supply S2 and S3 medicines. Nationally, medicines in S2 have been assessed as being safe for 'over the counter' supply from pharmacies and medicines in S3 have been assessed as being safe for 'over the counter' supply provided a pharmacist has determined that the medicine is therapeutically appropriate for the intended person.

Despite the Regulations not requiring a prescription for S2 and S3 medicines, that does not preclude a designated registered nurse prescriber choosing to issue a prescription, as a way of communicating their management plan to the supplying pharmacist. As with any supply of a scheduled medicine, the pharmacist must exercise their professional responsibility and this could include contacting the designated registered nurse prescriber, if they have any concerns about the requested supply.

It is proposed that designated registered nurse prescribers be regulated in the same way as other prescribers in that they can make a direct supply of S2 and S3 medicines, provided they are acting in the lawful practice of their profession. Essentially, this means a designated registered nurse prescribe would be authorised to supply the S2 and S3 medicines included in their prescribing agreement and supply must be in accordance with all relevant aspects of that prescribing agreement.

3. Consultation questions: Supply of Schedule 2 and Schedule 3 medicines by designated registered nurse prescribers

3.1 Should designated registered nurse prescribers be authorised to supply medicines in S2 and S3?

Please select ONE option.

☐ Yes ☐ No ☐ Unsure

3.2 If you answered 'no', please explain why you disagree with designated registered nurse prescribers supplying medicines in S2 and S3:

Collaborative pharmacist medication prescribing

Medication charting by pharmacists is a form of collaborative or partnered prescribing, where pharmacists, with demonstrated competency, in collaboration with the patient's treating medical team, chart medications for nursing staff to administer. In Australia, such charting is currently used in the hospital sector.

In other countries, pharmacists working in hospitals may prescribe under both collaborative arrangements and independently, depending on the timeline for development of prescribing by pharmacists more generally. For example, in the UK, independent (autonomous) pharmacist prescribing has been embedded within the healthcare system for nearly 20 years and, from September 2026, newly qualified pharmacists will be independent prescribers upon registration. This means UK hospital pharmacists, with prescribing rights, are eligible to prescribe autonomously, although they will be working as part of a multidisciplinary healthcare team in the hospital environment. In USA, there is variation across states with respect to prescribing by pharmacists, with protocol-based prescribing and collaborative prescribing arrangements being the predominate models.[22] In NZ, designated pharmacist prescribers must work within a multidisciplinary team and must only prescribe medicines within their specific area of practice. In the NZ hospital setting, pharmacist prescribers can initiate, modify and discontinue therapy, including a therapy initiated by another prescriber.[23]

In Australia, partnered medication charting arrangements were first piloted in 2012 at The Alfred Hospital in Melbourne and subsequently expanded to multiple hospitals across Victoria[24].

To date, the terms partnered pharmacist medication charting (PPMC), partnered pharmacist medication prescribing (PPMP), and collaborative pharmacist medication prescribing (CPMP) have been used somewhat interchangeably.

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[22] Evans A. Prescribing authority for pharmacists: rules and regulations by state, July 2022. Available at: https://www.goodrx.com/hcp-articles/pharmacists/prescriber-authority-for-pharmacists

[23] New Zealand Hospital Pharmacists' Association. Standards of Practice for New Zealand Hospital Clinical Pharmacy Services, June 2019. Available at: https://nzhpa.org.nz/assets/Uploads/NZHPA-Standards-of-Clinical-Practice-June-2019.pdf.

[24] Hua PU, Edwards G, Van Dyk E et al. Expansion of the partnered pharmacist medication charting model on admission in the General Medicine Unit – initiation of new medications. Pharm Prac Res 2023;53:26-31.

In WA, where pharmacists do not currently have prescribing rights, PPMC refers to the charting of medications by a pharmacist, with final sign off by a medical practitioner. In other states and territories, PPMC can refer to a pharmacist completing an administration order on a hospital medication chart without any requirement for medical practitioner sign off.

Since the initial implementation of PPMC/PPMP in Victoria, state-wide implementation has occurred in Tasmania and similar prescribing models have also been rolled out in various hospitals across New South Wales, Queensland, the Australian Capital Territory and South Australia.

A lead professional indemnity insurer for pharmacists has issued member guidance indicating that their master policy covers hospital pharmacists with the education, competence and authority to undertake PPMC/PPMP, where there is accountability for the pharmacist's actions personally and within the organisation[25].

PPMC/PPMP on admission has been demonstrated to significantly decrease the rate of medication errors per patient admission.[26,27] In various studies undertaken in Australian public hospitals, errors were detected in 10% or less of orders where partnered prescribing was used. In contrast, error rates were as high as 78.7% where standard medical charting was used.

Charting of the patient's regular medications by pharmacists, at the point of hospital admission, is more efficient than having the pharmacist undertake a medicines reconciliation process, after the admitting medical officer has charted the patient's usual medications. Any errors made by the medical officer will only be detected retrospectively and sometimes after an adverse outcome has occurred.

Studies have also shown a reduction in the median length of stay when partnered pharmacist charting is used and these results have been seen across public hospitals in metropolitan, regional and rural areas.

Partnered pharmacist prescribing on discharge has also been evaluated in several Australian studies.[25] Outcomes include significantly fewer discharge prescription errors and earlier discharge from the ward, which may improve overall patient flow.

From a cost perspective, an economic evaluation of PPMC, using data from seven metropolitan hospitals in Victoria, found an estimated average saving of $726 per patient. The same evaluation calculated the cost:benefit ratio to be 1:15.[28]

Barriers to implementation of PPMC/PPMP include concerns about potential de-skilling of junior medical officers (JMOs), prioritisation of pharmacy department resourcing to cover admissions and discharges outside traditional hospital pharmacy opening hours and variations in competency assessment of pharmacists between hospitals. Some data is available on the impact of PPMC/PPMP on junior doctors. Studies in Victoria[23] showed that

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[25] Available at: https://pdl.org.au/pdl-member-guidance-for-hospital-pharmacists-on-collaborative-pharmacist-led-charting-and-prescribing-cpcp/

[26] Tong EY, Yip G. Partnered pharmacist medication charting and prescribing in Australian hospitals. Aust Prescriber 2024;47:48-51.

[27] Taylor S, Hale A, Lewis R, Roland J. Collaborative doctor-pharmacist prescribing in the emergency department and admissions unit: a study of accuracy and safety. J Pharm Pract Res 2019;49:176-178.

[28] Dalton A, Beks H, McNamara K, Mania E, Mohebbi M. Health economic evaluation of the partnered pharmacist medication charting (PPMC) program. Deakin University 2020. Available via: https://www.safercare.vic.gov.au/improvement/projects/ppmc.

only 10 to 22% of JMOs were concerned about de-skilling while 100% of JMOs wanted partnered prescribing to continue. Overall, both JMOs and nurses believed benefits to patient safety, patient flow and JMO workload outweighed any potential for de-skilling.

In WA, a limited study of PPMC on admission in one medical unit at a metropolitan tertiary hospital was able to replicate the reduction in prescribing errors found in the Victorian studies.[29] At the same hospital, a survey of medical practitioner support for PPMC/PPMP found 77.8% of doctors felt continuation of PPMC/PPMP would be of benefit to their team and the hospital[30]. There was a high level of support (82% of respondents) for pharmacists prescribing medications on admission, 69% support for pharmacists prescribing new medications and amending existing orders and 50% support for pharmacists prescribing in accordance with approved protocols.

In the hospital setting, it is expected that governance frameworks, to enable formal prescribing agreements between autonomous prescribers and pharmacists with demonstrated competency, would include an assessment of the prescribing of high-risk medicines, including, but not limited to, S8 medicines and chemotherapy agents.

Pharmacist prescribing in community pharmacies

International experience

In countries with similar regulatory schemes to Australia, over time there has been a progression from pharmacist initiation of prescription medicines for a few specific indications such as oral contraception and uncomplicated urinary tract infections, followed by prescribing for a wider range of common health conditions through to independent prescribing determined by scope of practice. In common with Australia, there can be variation between jurisdictions within a country as to the extent of development of pharmacist prescribing. For example, as of late 2024, in Alberta, Canada certain qualified pharmacists could diagnose and initiate prescription medicines within their personal scope of practice, whilst in other Canadian provinces, pharmacist prescribers are limited to treatment of specific conditions as well as renewing and adapting prescriptions for medicines previously prescribed by a medical practitioner.[31]

In NZ, community pharmacists who have undertaken specific additional training have been supplying antibiotics for urinary tract infections since 2012, sildenafil for erectile dysfunction since 2014 and re-supply of selected oral contraceptives since 2017. These schemes are regulated by an exemption for pharmacist supply of these ‘prescription only’ medicines, under defined circumstances.

NZ also has pharmacists registered as ‘pharmacist prescribers’.[32] These prescribers must work within a collaborative health team environment with other healthcare professionals and are not the primary diagnostician. This means these pharmacist prescribers practice within

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[29] Sinclair VL, Hitchen SA, Rawlins MDM, Tong EY. Validating the Victorian partnered pharmacist charting model in the Western Australian setting. J Pharm Pract Res 2020;50:456-457.
[30] Thorson R, Jenkins B. Exploring the views of medical practitioners on proposed legislative changes in Western Australia to support supervised pharmacist prescribing in the hospital setting. J Pharm Pract Red 2025 (online early view): https://doi.org/10.1002/jppr.70026
[31] Mesbahi Z, Piquer-Martinez C, Benrimoj SI et al. Pharmacists as independent prescribers in community pharmacy: A scoping review. Res Social Adm Pharm 2025;21:142-153.
[32] https://pharmacycouncil.org.nz/public/pharmacist-scopes-of-practice/

general practices and secondary care locations, such as hospitals. Pharmacist prescribers can have a pecuniary interest in a community pharmacy with the consent of the licensing authority, usually on the condition that prescriptions issued by that pharmacist prescriber are not dispensed at the pharmacy in which they have a pecuniary interest.

In the UK, Canada and NZ, a barrier to the development of pharmacist prescribing in community pharmacies has been funding and reimbursement.[33] Other implementation barriers include socio-political context and prescriber training and competence.

Consultation services at pharmacies for minor ailments, including supply of medicines for these ailments, have been funded in England, Scotland and Wales for around 5 to 6 years. Whilst the majority of the medicines able to be supplied under these services are pharmacy 'over the counter' products, there are a few 'prescription only' medicines included, such as some antibiotics. However, in contrast to hospitals and general practices, broader independent prescribing by pharmacists working in community pharmacies has, until recently, been much less common. In England, service delivery of the Independent Prescribing in Community Pharmacy Pathfinder Programme commenced in August 2024 and as of May 2025, more than 17,000 pharmacist-patient consultations had occurred under the program.[34] The program will be subject to an independent qualitative evaluation, after which broader rollout of NHS England funded independent prescribing in community pharmacies is anticipated.

Australian experience

Protocol-based supply of specific S4 medicines by pharmacists, without a prescription, has been implemented in all states and territories over the last few years, including antibiotic treatment of uncomplicated urinary tract infections and re-supply of oral contraceptive pills. Pharmacists are also authorised to administer vaccines, all of which are classified as S4 medicines, across Australia. There are also limited circumstances where pharmacists can supply an extra quantity of many Pharmaceutical Benefits Scheme (PBS) items, where the patient is under chronic treatment with the medication and cannot obtain a new prescription from their doctor in a timely manner.

In 2022, Queensland was the first jurisdiction in Australia to announce an expanded scope of practice pilot to allow community pharmacists, who have undertaken additional post-graduate training, to prescribe S4 medicines, in accordance with approved protocols, for a defined list of common health conditions. Initially, the pilot was to be limited to North Queensland but in September 2023 was expanded to the whole state. The Queensland Community Pharmacy Scope of Practice Pilot officially launched on 24 April 2024. Treatment of a defined list of acute health conditions by pharmacists was transitioned to a 'business as usual' model from 1 July 2025. Management of some chronic conditions are now part of a separate pilot, where pharmacists are authorised to undertake protocol-based prescribing in the Queensland Community Pharmacy Chronic Conditions Management Pilot.

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[33] Zhou M, Desborough J, Parkinson A et al. Barriers to pharmacist prescribing: a scoping review comparing the UK, New Zealand, Canadian and Australian experiences. Int J Pharm Prac 2019;27:479-489.
[34] Robertson J. More than 17,000 community pharmacist prescribing consultations so far. News report from Clinical Pharmacy Congress, London. Available at: https://www.thepharmacist.co.uk/in-practice/more-than-17000-community-pharmacist-prescribing-consultations-so-far/

Other states and territories have announced the development of similar expanded scope services through community pharmacies[35,36,37,38] although there are some variations in the conditions pharmacists will be eligible to treat. Most of these services are flagged for commencement in early 2026. In addition, Tasmania has announced that pharmacists will be able to prescribe medications in aged care settings.[39]

In December 2022, the Consumer Health Forum surveyed consumers on their attitudes to prescribing by pharmacists within community pharmacies, via their Health Panel.[40] Consumers were largely in favour of pharmacists being given some prescribing powers, particularly in relation to 'repeat' prescriptions for treatment of ongoing health conditions, where the condition had been diagnosed and treated by a doctor previously. The second scenario acceptable to consumers was use of pharmacists to fill a gap to ensure medication was affordable and accessible, such as for treatment of urgent or low-risk conditions that could be reliably diagnosed by pharmacists. Consumers thought pharmacists should have greater capacity to prescribe in areas with low numbers of general practitioners, such as rural and remote locations.

In the Consumer Health Forum survey, consumers believed pharmacists would require additional training, particularly in relation to diagnostic skills, and pharmacy premises may need modification to ensure patient privacy and confidentiality.

Currently, protocol-based prescribing by community pharmacists in other Australian states and territories is limited to S4 medicines and the WA EACPP will be similarly limited.

However, future expansion of pharmacist prescribing in community settings could include prescribing of S8 medicines. As for all other prescribers, compliance with the additional requirements in the Act and Regulations pertaining to monitored medicines, which includes S8 medicines and higher risk S4 medicines, would also be required for pharmacists. For example, prescribing of S4 monitored medicines and S8 medicines would need to be in accordance with the Monitored Medicines Prescribing Code, including utilising information provided through ScriptCheckWA. Pharmacists already have access to ScriptCheckWA.

Separation of prescribing and dispensing functions

It is important to acknowledge that, under the Medicines and Poisons legislation, pharmacists are the only profession authorised to dispense a prescription written by another health practitioner. Other health practitioners, with prescribing rights, are authorised to make a direct supply of a medicine to their own patient, provided the medicine is one which they are also allowed to prescribe. However, in most circumstances, health practitioners will issue a prescription rather than making a direct supply.

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35 https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Department+for+Health+and+Wellbeing/Office+of+the+Chief+Pharmacist/Community+pharmacy+initiatives/Community+Pharmacy+Expanded+Scope+of+Practice+initiative

36 https://newsroom.nt.gov.au/article?id=3690ff91ad19b3438b2a9a5fd6b6d996

37 https://www.health.vic.gov.au/primary-care/community-pharmacist-program

38 https://www.health.nsw.gov.au/pharmaceutical/Pages/services.aspx#future

39 https://www.premier.tas.gov.au/latest-news/2025/may/expanding-the-scope-of-practice-for-tasmanian-pharmacies

40 https://www.chf.org.au/get-involved/australia-s-health-panel/what-australia-s-health-panel-said-about-pharmacy-prescribing-december-2022

The separation of prescribing and dispensing functions is intended to uphold medication safety principles, where the dispensing pharmacist independently evaluates the safety and suitability of the prescription before the medicine is supplied to the patient.

In March/April 2019, the Pharmacy Board of Australia undertook public consultation on prescribing by pharmacists. Consultation responses supported pharmacists participating in collaborative prescribing arrangements, provided there was separation of prescribing and dispensing.[41, 42] Some respondents took the view that a risk-based approach was appropriate and considered the decision to separate prescribing and dispensing may only be required for high-risk medicines or where any professional conflict of interest could not be adequately managed.[30,43, 44]

Regulatory options for pharmacist prescribing

Unlike other health practitioner classes, who are already considered qualified to prescribe by their national registration Board via an endorsement for scheduled medicines, the Pharmacy Board of Australia has only recently announced they will be pursuing an endorsement process to support pharmacist prescribing. The Pharmacy Board is currently seeking members of an expert advisory committee on pharmacist prescribing, which is the first stage of their development of an endorsement for pharmacists.

In December 2023, the Australian Pharmacy Council (APC) published accreditation standards to support independent prescribing by pharmacists[45]. The Standards for Pharmacist Prescriber education programs are already in use with accreditation of a number of education programs, provided by universities and registered training organisations. These education programs have been designed to support the expanded access programs being implemented across all states and territories, including the WA EACPP.

As the proposed Pharmacy Board endorsement for scheduled medicines prescribing is still under development, this means any authorisation for pharmacists to prescribe, via the Medicines and Poisons Regulations 2016, must include the detail necessary to set the boundaries to keep patients and the broader public safe.

Prescribing of Schedule 4 and Schedule 8 medicines

Regulatory Option 1: No change, pharmacists are not authorised to prescribe in WA (status quo)

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[41] Pharmaceutical Society of Australia. Pharmacist prescribing on the way. Available at: Pharmacist prescribing on the way - Pharmaceutical Society of Australia

[42] Australian Medical Association. Response to Pharmacy Board of Australian public consultation on pharmacist prescribing, March/April 2019. Available at: https://www.pharmacyboard.gov.au/documents/default.aspx?record=WD19%2f28640&dbid=AP&chksum=FkeAMR9%2f4fzuftzpjj2xaw%3d%3d

[43] NPS MedicineWise. Response to Pharmacy Board of Australian public consultation on pharmacist prescribing, March/April 2019. Available at: https://www.pharmacyboard.gov.au/documents/default.aspx?record=WD19%2f28631&dbid=AP&chksum=%2ftmZ8XZdFzfXBnqlsfX7Bg%3d%3d

[44] Pharmacy Guild of Australia. Response to Pharmacy Board of Australian public consultation on pharmacist prescribing, March/April 2019. Available at: https://www.pharmacyboard.gov.au/documents/default.aspx?record=WD19%2f28661&dbid=AP&chksum=q1PpNlpKnx3V8DhYph%2fmfw%3d%3d

[45] Available at: https://www.pharmacycouncil.org.au/resources/Accreditation-Standards-for-Pharmacist-Prescriber-education-programs/

Regulatory Option 2: Authorise pharmacists to prescribe and detail specific requirements within the Regulations.

The specific requirements would depend on the prescribing model with which the pharmacist is involved. For example, regulatory requirements for the EACPP could include:

- Pharmacists must successfully complete an education program approved by the Department of Health.
- Pharmacists must only issue prescriptions when practising in a setting that meets the EACPP consultation room requirements.
- Pharmacists must prescribe in accordance with the EACPP clinical guidelines and protocols.

Further information about the requirements of the EACPP are available via the Department's website at: https://www.health.wa.gov.au/Articles/A_E/Enhanced-Access-Community-Pharmacy-Pilot.

A separate, and different, set of regulatory requirements would be needed for hospital-based Collaborative Pharmacist Medication Prescribing (CPMP). For example, a regulatory framework for governance over prescribing agreements would be required.

Inclusion of this detail within the Regulations themselves is not the preferred option, as the future development of pharmacist prescribing, including via a Pharmacy Board endorsement, would not be adequately supported without further amendment of the Regulations.

Regulatory Option 3: Authorise pharmacists to prescribe and require that prescribing be in accordance with a 'prescribing instrument'. This is the preferred option.

Information included in a prescribing instrument would be similar to the requirements described in Option 2. This is the preferred option, as a prescribing instrument can be more responsive to the development of pharmacist prescribing, as this practice matures over time.

Use of a 'prescribing instrument' is modelled on the framework used for the regulation of prescribing of monitored medicines[46]. For monitored medicines, authorised prescribers must adhere to the Monitored Medicines Prescribing Code[47], which is mandated by being referenced in the Regulations. This prescribing code outlines specific requirements aimed at reducing the public health risks linked to prescribing of monitored medicines.

Although the content of a 'prescribing instrument' for pharmacists would be different, the aim would similarly be to include specific requirements to mitigate public health risks associated with prescribing by pharmacists.

In line with other approvals under the Act and Regulations, including the Monitored Medicines Prescribing Code, a prescribing instrument would be approved by the Chief Executive Officer of the Department of Health (CEO) or their delegate.

Use of a prescribing instrument accommodates future development of pharmacist prescribing, including prescribing via an endorsement by the Pharmacy Board of Australia. Although the first version of the prescribing instrument will only support prescribing within the

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[46] Monitored medicines are medicines included in Schedule 8 plus certain medicines in Schedule 4 that are associated with a higher risk of dependence. Schedule 4 monitored medicines, also known as Schedule 4 reportable poisons, are listed in Schedule 6 of the Medicines and Poisons Regulations 2016.
[47] Available at: https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Medicines-and-Poisons/PDF/Monitored-Medicines-Prescribing-Code.pdf.

Enhanced Access Community Pharmacy Pilot (EACPP) and hospital-based Collaborative Pharmacist Medication Prescribing (CPMP), use of a prescribing instrument would provide flexibility to introduce collaborative prescribing arrangements in other clinical settings, such as medical practices and residential aged care facilities.

Any prescribing instrument would be published on the Department's website.

Advantages and disadvantages of each Regulatory Option are shown in the following table:

Table 3: Advantages and disadvantages of Regulatory Options

Option	Advantages	Disadvantages
Option 1: No authorisation to prescribe (Status quo)	No change.	When working in WA, pharmacists who have successfully completed pharmacist prescriber education programs will not be able to work at the scope level for which they are trained. The EACPP and CPMP cannot commence. Lack of alignment with other states and territories. Potential benefits from prescribing by pharmacists cannot be realised.
Option 2: Include specific requirements in Regulations	Clearly indicates what is required of a pharmacist with prescribing rights, to comply with the Medicines and Poisons Regulations.	Limited flexibility to accommodate changes in prescribing practice – future regulatory amendment very likely to be required. Lack of alignment with protocols and guidelines associated with specific programs may occur over time.
Option 3: Include specific requirements in a 'prescribing instrument'	Through the 'prescribing instrument' referenced by the Regulations, clearly indicates what is required of a pharmacist with prescribing rights. Greater flexibility to accommodate changes in prescribing practice. Can reference protocols and guidelines associated with specific programs, such as EACPP.	Could potentially be used to introduce barriers to prescribing that extend beyond ensuring protection of public health. Preferred option.

4. Consultation questions: Regulatory options for pharmacist prescribing

4.1 Which Regulatory Option do you support for prescribing by pharmacists?

Please select ONE option

☐ Option 1: Do not authorise prescribing (status quo)	☐ Option 2: Authorise prescribing and include details in Regulations	☐ Option 3: Authorise prescribing and include details in a mandatory 'prescribing instrument'	☐ None of the options are suitable	☐ Unable to comment

4.2 If you chose Regulatory Option 3 (prescribing instrument), please explain why you support use of a mandatory prescribing instrument for pharmacists:

4.3 If you do not support use of a mandatory prescribing instrument, why is this?

5. Consultation questions: Prescribing of Schedule 8 medicines by pharmacists

5.1 How supportive are you of pharmacists issuing prescriptions for Schedule 8 medicines, even if this is at a future time (controlled drugs like morphine, oxycodone, tapentadol, dexamfetamine, methylphenidate)?

Please indicate your level of support by choosing ONE option:

☐ Very supportive	☐ Somewhat supportive	☐ Neither supportive nor unsupportive	☐ Somewhat unsupportive	☐ Very unsupportive

5.2 If you answered 'very unsupportive' or 'somewhat unsupportive', please explain why you chose this option:

5.3 Please select any of the following factors that would increase your level of support for Schedule 8 prescribing by pharmacists (you may select as may factors as you wish):

☐ Limit Schedule 8 prescribing to oral opioids (medicines like oxycodone and tapentadol) for treatment of acute pain.

☐ Only allow pharmacists to prescribe up to 14 days treatment.

☐ Not allow repeats to be prescribed.

☐ Only allow prescribing in situations where no authorisation from the WA Department of Health is required. For example: no prescribing to people experiencing drug dependence, no prescribing of injectable forms (end of life care excepted), no high dose opioid prescribing.

☐ Only allow prescribing of fully TGA registered products (this means medicinal cannabis would be excluded).

☐ Not allow prescribing of stimulant medicines such as lisdexamfetamine, dexamfetamine or methylphenidate, even where the medicines were commenced by a specialist prescriber.

☐ Allow all prescribing of Schedule 8 medicines in settings where the patient does not have custody of their medicines, such as for hospital inpatients and people in residential care.

☐ Only allow Schedule 8 prescribing for adult patients.

☐ None of the above factors would increase my support for S8 prescribing by pharmacists.

5.4 If there are any other factors which would increase your support for Schedule 8 prescribing by pharmacists, please provide details:

Prescribing instrument for pharmacists

This section is about the type of information which could be included in a prescribing instrument for pharmacists.

Collaborative pharmacist medication prescribing (CPMP)

The Department of Health is currently working with WA Health's Health Service Providers and other stakeholders, to determine processes for pharmacist competency assessment, governance and agreements between pharmacist prescribers and autonomous prescribers.

Pharmacist prescribing in community pharmacies

Detailed information about the Enhanced Access Community Pharmacy Pilot (EACPP) is available on the WA Health website at: https://www.health.wa.gov.au/Articles/A_E/Enhanced-Access-Community-Pharmacy-Pilot. This information already includes:

- the training requirements for pharmacists to be eligible to participate in the EACPP
- requirements for pharmacy premises, with a focus on privacy, confidentiality and patient safety and
- comments on clinical guidelines and protocols which will guide pharmacists.

6. Consultation questions: Prescribing instrument content applicable to collaborative prescribing by pharmacists

6.1 Which of the following topics should be included in a prescribing instrument for pharmacists to support collaborative prescribing?

In each section, please select as many options as you wish.

Governance

☐ Processes for competency assessment of pharmacist prescribers

☐ Governance framework for agreements with autonomous prescribers.

Prerequisites and training

☐ Prerequisites, such as years of clinical experience and recency of practice.

☐ Required competencies for a pharmacist to participate in collaborative prescribing agreements.

☐ Required formal training.

☐ Continuing professional development (CPD) requirements.

☐ Reassessment/refresher requirements.

Elements to be included in prescribing agreements

☐ ype of practice site. For example: the practice site could be a public hospital, general practice, residential aged care facility.

☐ Type of prescription. For example: inpatient medication chart, outpatient prescription, discharge prescription.

☐ Details of medicines that can be prescribed. For example: a list of medicines (formulary), a clinical protocol or reference to a guideline (such as the Australian Therapeutic Guidelines), medicines included in each patient's clinical management plan, restrictions to certain schedules.

☐ Details of the health conditions for which pharmacists can prescribe treatment

☐ Prescribing limits. For example, whether a pharmacist can initiate a new medicine, substitute a medicine with another in the same class, change formulation, duration of prescribing, when to refer to an autonomous prescriber.

☐ Record keeping requirements. For example: clinical record of consultation with patient.

6.2 Please provide details of any other information you think should be included in a Prescribing Instrument for Pharmacists to support collaborative prescribing:

7. Consultation questions: Collaborate prescribing agreements between pharmacist prescribers and autonomous prescribers

7.1 Which autonomous prescribers should be able to enter into a prescribing agreement with a pharmacist?

Select all that apply:

☐ Medical practitioner	☐ Nurse practitioner	☐ Dentist	☐ Endorsed midwife	☐ Endorsed podiatrist	☐ Endorsed optometrist

7.2 If you did not select all the autonomous prescribers, please explain why you excluded certain classes of autonomous prescriber:

7.3 In the hospital setting, should each prescribing agreement be approved by a Drug and Therapeutics Committee or equivalent?

Please select ONE option.

☐ Yes ☐ No ☐ Unsure

7.4 If you answered Yes to question 7.3, please explain why you chose this answer:

7.5 If you answered No to question 7.3, please explain why you chose this answer:

7.6 Within a health organisation, should a prescribing agreement apply to all pharmacists with demonstrated competency or should each agreement only apply to a named pharmacist? Please select one option.

☐ All pharmacists with demonstrated competency	☐ A named pharmacist only	☐ Both options are suitable	☐ Unsure

7.7 When should the prescribing agreement be reviewed? Please select as many options as you wish.

☐ At a fixed time period, such as annually or every 2 years.

☐ If requested by the pharmacist prescriber.

☐ If requested by the autonomous prescriber.

☐ If requested by the Drug and Therapeutics Committee or equivalent.

☐ If requested by the Department of Health.

☐ Other – please provide details below:

8. Consultation questions: Prescribing instrument content applicable to the Enhanced Access Community Pharmacy Pilot (EACPP)

8.1 Which of the following topics should be included in a prescribing instrument for pharmacists to support the EACPP?

In each section, please select as many options as you wish.

Governance

☐ Separation of prescribing and dispensing – policy and procedure requirements.

☐ Requirements for advice to patient's usual primary care prescriber

Prerequisites and training

☐ Prerequisites, such as years of clinical experience and recency of practice.

☐ Required formal training or, in the future, required endorsement by the Pharmacy Board.

☐ Continuing professional development (CPD) requirements.

☐ Reassessment/refresher requirements.

Resources and record-keeping

☐ Service to be conducted at registered pharmacy premises.

☐ Dedicated consulting room that ensures patient's privacy and confidentiality.

☐ Sufficient space within consulting room for patient, carer/support person, pharmacist, consumables, equipment and documentation.

☐ Secure system for record keeping.

☐ Requirement to keep a consultation record, including a documented treatment plan.

8.2 Please provide details of any other information you think should be included in a prescribing instrument for pharmacists to support the EACPP:

Withdrawal of prescribing agreements

In the event that a prescribing agreement is considered to pose a significant risk to the health, safety or welfare of a person or the public, a regulatory option is to include a provision to allow the Chief Executive Officer (CEO) of the Department of Health to direct the agreement be withdrawn. Such a provision would be applicable to a prescribing agreement between any class of health practitioner, including prescribing agreements involving both pharmacists and designated registered nurse prescribers.

A similar withdrawal provision already exists within the Regulations, for Structured Administration and Supply Arrangements (SASAs) issued by health organisations and issued by individual medical practitioners.

An alternative could be to use the provisions within the Act, which allow the CEO of the Department to restrict the professional authority an authorised health professional, with respect to their handling of scheduled medicines. Where there were significant concerns about the safety of a prescribing agreement, a health practitioner could have a condition placed on their professional authority that prevented them from entering into prescribing agreements. The Act includes clauses that provide the health professional with an opportunity to be heard on the matter, and a right of review via the State Administrative Tribunal. The Act also allows the Department to advise the health practitioner's registration board if action is taken to restrict, suspend or cancel their professional authority.

9. Consultation questions: Requirement to withdraw a prescribing agreement

9.1 How supportive are you of a regulation that allows the Department to direct the withdrawal of a prescribing agreement, where there is significant risk to the health, safety and welfare of a person or the public?

Please indicate your level of support by choosing one option:

☐ Very supportive	☐ Somewhat supportive	☐ Neither supportive nor unsupportive	☐ Somewhat unsupportive	☐ Very unsupportive

9.2 How supportive are you of using the current provisions in the Act, to restrict a health practitioner's professional authority, instead of there being a specific regulation about withdrawal of prescribing agreements?

Please indicate your level of support by choosing one option:

☐ Very supportive	☐ Somewhat supportive	☐ Neither supportive nor unsupportive	☐ Somewhat unsupportive	☐ Very unsupportive

How to respond to the consultation

Stakeholders are encouraged to provide responses via the Department's Citizen Space consultation website at: https://consultation.health.wa.gov.au/. The survey on the website includes the same consultation questions as the Consultation discussion paper.

Alternatively, stakeholders may submit their response by completing the questions within the Consultation discussion paper and emailing a copy to the Medicines and Poisons Regulation Branch via MPRB@health.wa.gov.au. If you provide feedback via this pathway, please ensure you also complete the following information or include this information in your covering email:

1. How would you like your submission to be treated? (choose ONE option)
   - ☐ Publish my submission with my name and/or the name of the organisation
   - ☐ Publish my submission anonymously
   - ☐ Do not publish my submission (confidential submission)
2. Are you responding as an individual or providing the view of an organisation (choose ONE option):
   - ☐ Responding as an individual
   - ☐ Providing the views of an organisation
3. If you are responding as an organisation, please provide the name of the organisation:
   Click or tap here to enter text.
4. If you are responding as an individual please provide your name (optional):
   Click or tap here to enter text.
5. If you are responding as an individual, it is optional to provide your name but please select which ONE of the following options below best describes you. If none of the options applies, please include your own description.
   - ☐ Health consumer
   - ☐ Medical practitioner
   - ☐ Nurse practitioner
   - ☐ Pharmacist
   - ☐ Dentist
   - ☐ Registered nurse (but not a nurse practitioner)
   - ☐ Midwife (but not a registered nurse)
   - ☐ Enrolled nurse
   - ☐ Other registered health practitioner
   - ☐ Other health professional, but not AHPRA registered
   - ☐ Operator of a health-related business
   - ☐ Operator of a business, not health-related
   - ☐ Other: Click or tap here to enter text.

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