

Newfoundland and Labrador Pharmacy Board Standards of Practice



**Standards for the Safe and Effective Provision of
Medication for the Treatment of Opioid Dependence**

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1) Introduction

Substance dependence is a medical illness. It is a chronic and relapsing disorder, not an acute condition that can be rapidly cured by detoxification. The cost of this illness to the individual and to society is significant, and can include severe decline of the individual's physical and psychological health, unemployment, family disruption, and participation in criminal activities such as prostitution, theft and trafficking. Relapses are a common part of recovery. The fact that these patients are also at a high risk for concomitant health conditions and comorbidities only serves to complicate the matter and demonstrate the need to a holistic approach to the patient.

The goal of a treatment program for opioid dependence should be to provide broad access to effective treatments that are assessed, administered, monitored, and supported by experts trained in addiction to ensure optimal safety and efficacy from the therapy. These experts not only use their skills and knowledge to make appropriate decisions about the use of available treatments, but must also understand the complex challenges of addiction and be able to provide guidance and support for the psychosocial aspects that can complicate the lives of individuals with opioid dependence.

Options for medication-assisted treatment for opioid dependence include opioid agonist therapy (also known as opioid substitution therapy) with methadone or buprenorphine. Buprenorphine products indicated for the treatment of opioid dependence (Suboxone® and generics) include naloxone which is included to deter against diversion and injection abuse. Since methadone itself can result in physiological dependence, for some, methadone or buprenorphine-naloxone therapy may be required chronically in order to prevent relapse. Medication-assisted treatment for opioid dependence is based on harm reduction and serves to bring normal functioning back to an individual. The benefits can be physiological, psychological, and social. Treatment success is not contingent on an individual being able to eventually stop medication-assisted treatment and to continue to remain abstinent from opioids, although this is an ideal outcome. When used as part of a maintenance program, methadone and buprenorphine-naloxone cause little to no euphoric effect, but enable suppression of the withdrawal symptoms and cravings experienced in opioid addiction that often contributes to relapse.

Also critical to the success of medication-assisted treatment for opioid dependence is collaboration between the health professionals involved in the care of the patient. Many problems in patient care have been found to be a direct result of lack of communication between the prescriber and the pharmacist. Effective collaboration and communication between physicians and pharmacists is essential and can have a positive impact on patient care and safety.

These Standards are intended to provide information and guidance to pharmacists involved in medication-assisted treatment of opioid dependence and to promote consistency in the provision of such medications to the people of this province. This document is intended to be complementary to the Methadone Maintenance Treatment Standards and Guidelines adopted by the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL). Any perceived inconsistencies between these Standards and those of the CPSNL, or any other comments or suggestions for improvement, should be forwarded to the Newfoundland and Labrador Pharmacy Board.

2) Treatment Choices

The choice between methadone and buprenorphine-naloxone will depend on a number of factors including (but not limited to):

- The degree of opioid dependence and tolerance experienced by the patient,
- An evaluation of the patient's risk of harm from the chosen therapy, including the risk of non-compliance,
- The patient's allergies, concomitant health conditions and comorbidities,
- The potential for significant drug interactions with other concomitant therapies,

- The patient's ability to access the specialized services and expertise of an opioid dependence program,
- The patient's response to therapy,
- The patient's ability to afford the chosen therapy, and
- The patient's lifestyle and social history.

Methadone is a full opioid agonist and, as such, has no ceiling effect. Although it is generally more effective than buprenorphine-naloxone in treating those dependent on higher opioid doses, the lack of a ceiling effect can pose an increased risk of harm from overdose, drug interactions, or other circumstances which can lead to increased methadone serum levels.

Buprenorphine is a partial opioid agonist at the μ (mu) receptor. It is associated with a reduced risk of death in overdose compared to full opioid agonists (e.g. methadone) because it has a ceiling effect to adverse effects such as respiratory depression. This is why many clinicians consider buprenorphine to be a safer drug than methadone. However, buprenorphine's ceiling effect may also result in limitations since its effectiveness plateaus once a certain serum level is reached.

For more information on methadone and buprenorphine for treatment of opioid dependence, see the comparison table attached in Appendix I.

3) Pharmacist Requirements for Participation in Medication-Assisted Opioid Dependence Treatment

In order to receive authorization from the Board to participate in medication-assisted treatment of opioid dependence, pharmacists must first:

- a) apply to the Newfoundland and Labrador Pharmacy Board for authorization; and
- b) provide proof of successful completion of an education program on the use of medication in the treatment of opioid dependence approved by the Board;

NOTE: Applications for authorization must be made within one year of successful completion of the required education program.

Applications will be reviewed and, if approved, authorization will be issued to the pharmacist. Once authorized, the pharmacist must:

- a) maintain competence in medication-assisted treatment of opioid dependence. Continuing professional development should be undertaken, as necessary, to maintain knowledge and skills.
- b) agree to provide medication for the treatment of opioid dependence only in accordance with the standards established by the Newfoundland and Labrador Pharmacy Board, and within the limits of their own competence

4) Operational Standards for Participation in Medication-Assisted Opioid Dependence Treatment

Before permitting medications for opioid dependence to be dispensed at the pharmacy under their supervision, the pharmacist-in-charge must first apply to the Newfoundland and Labrador Pharmacy Board to register the pharmacy as a site for opioid dependence treatment.

Applications will be reviewed and, if approved, authorization will be issued to the pharmacist-in-charge. Once authorized, the pharmacist-in-charge must ensure that the pharmacy meets certain minimum operational standards on an on-going basis:

- a) *Pharmacy Layout and Design.* The pharmacy must be designed and laid out to allow for all pharmacist-patient discussions, witnessed doses and the provision of take home doses to take place in a patient care environment that ensures visual and acoustical privacy and confidentiality and that is clean, safe, and comfortably furnished for the patient.
- b) *Hours of Operation.* When a pharmacy accepts a patient who requires daily witnessed ingestion of medication, the pharmacy should be prepared to accommodate this dosing requirement and maintain hours of operation necessary to do so. Pharmacies that do not operate seven days a week must facilitate arrangements to enable the patient to acquire their doses on the days the pharmacy is closed. This may include: opening at selected times on the day(s) the pharmacy is closed to service pre-scheduled patients who require witnessed daily doses, collaboration with physicians for authorization of take-home doses for the selected days the pharmacy is closed (if deemed safe for the patient), or collaboration with physicians and another pharmacy to arrange dosing at an alternate site.
- c) *Pharmacy Network.* In order to allow for documentation in the patient's provincial health record, it is strongly recommended that pharmacies participating in opioid dependence treatment are connected to the provincial electronic health record through the Pharmacy Network¹.
- d) *Staff Education.* It is the responsibility of the pharmacist-in-charge to ensure that all pharmacist and non-pharmacist staff are appropriately educated and trained and understand the scope of their role in the provision of medications for the treatment of opioid dependence.
- e) *Security.* Security of the premises should address the potential risks associated with the provision of medication for the treatment of opioid dependence and the risks to the community that can result from theft of methadone or buprenorphine-naloxone. As with other narcotics, preparations containing methadone and buprenorphine should be stored in a locked and secure location at all times (i.e., during hours of operation and when the premises are closed for business).
- f) *Policy and Procedure Manual.* The pharmacy must develop, maintain and regularly review a policy and procedure manual related to the provision of medications for the treatment of opioid dependence.
- g) *Required References.* In addition to this document, the following must be available in the pharmacy in either print or electronic format for staff reference:
 - i) CPSNL Methadone Maintenance Treatment Standards and Guidelines
www.cpsnl.ca/default.asp?com=Policies&m=360&y=&id=93
 - ii) Health Canada Best Practices: Methadone Maintenance Treatment
www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/methadone-bp-mp/index-eng.php
 - iii) Opioid Agonist Maintenance Treatment, 3rd edition
<http://store-camh.myshopify.com/collections/english-anglais/products/p6500>
 - iv) Centre for Addictions and Mental Health (CAMH) Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline
<https://www.porticonetwork.ca/documents/507864/0/buprenophin+guideline+2012/ef7d9c7a-d1b4-46b7-b566-7207c31ac1b7>

¹ This recommendation is in place until such time as all pharmacies are connected to the provincial electronic health record.

5) Practice Standards for Participation in Methadone Maintenance Treatment

5.1 Collaboration Between the Pharmacist and the Prescriber

- a) *Verbal Discussion.* In accordance with their Standards and Guidelines, physicians are expected to have a verbal discussion with a pharmacist at the patient's pharmacy outlining the details of the physician's treatment agreement with the patient along with his or her expectations regarding missed doses and intoxication, among other things, prior to initiating methadone.
- b) *Written Agreement.* Physicians are also encouraged to send a written Physician-Pharmacist Treatment Agreement (see Appendix II for a sample of this agreement) to the patient's pharmacy that puts in writing the information identified in a) above. This document should also include the physician's contact information for use by the pharmacist in situations where the pharmacist needs to contact the physician or in the case of an emergency.

Once received, this agreement should be reviewed by the pharmacy staff, signed and a copy returned to the physician for their records.

If the pharmacist has not had this verbal discussion with the physician or is not in receipt of the Physician-Pharmacist Treatment Agreement, it is recommended that they contact the prescribing physician prior to dispensing methadone to the patient. If this is not possible, the rationale for this deviation should be documented in the patient record.

5.2 Establishing the Pharmacist – Patient Relationship

- a) *Verbal Discussion.* Pharmacists should arrange for an initial meeting with the patient to discuss the services that they will provide, along with the obligations and expectations of both the pharmacy staff and the patient within this relationship. The patient should be given the opportunity to ask questions and relevant written information should be made available to supplement the discussion.
- b) *Written Agreement.* A written Pharmacy-Patient Agreement serves to outline the roles, expectations and obligations of both parties and can go a long way to prevent and/or handle any misunderstandings that may occur in the future.

Such an agreement must be developed by the pharmacy and read and signed by both the patient and the pharmacist prior to methadone being dispensed (See Appendix III for a template Pharmacy-Patient Agreement for Methadone Maintenance Treatment).

NOTE: Since some patients may not be as receptive to information as would be ideal during this initial discussion, it may be advisable to revisit the agreement with them within a reasonable time period (generally, within two weeks).

5.3 Assessing the Prescription

- a) *Prescriber Eligibility.* Prior to dispensing methadone for opioid dependence, the pharmacist must first confirm that the physician is eligible to prescribe the medication for this purpose. The physician must have an exemption from Health Canada to prescribe methadone for opioid dependence.

Pharmacists can best verify the prescriber's eligibility by contacting the Office of Controlled Substances Methadone Program at:

Email: exemption@hc-sc.gc.ca

Telephone: (613) 946-5139

Toll-Free: 1-866-358-0453

Alternatively, pharmacists can contact the CPSNL at (709) 726-8546 for information related to prescribers.

- b) *Tamper Resistant Prescription Drug Pad Program Form.* In NL, all prescriptions for methadone must be written on the TRPP form, as required by the Tamper Resistant Prescription Drug Pad Program. This form is required regardless of whether the prescription is written by an in-province or out-of-province prescriber.

For more information on this program and its requirements, visit the Department of Health and Community Services website at http://www.health.gov.nl.ca/health/prescription/hcp_tamperresistantdrugpad.html.

- c) *Required Information.* The prescription must be appropriately signed and dated and also specify:
- The daily dose of methadone in milligrams, written in both numbers and words
 - The start date and end date of the prescription
 - The total number of witnessed doses of methadone, written in both numbers and words and the days of the week that doses are to be witnessed
 - If take-home doses are authorized, the number of take-home doses per week and the days of the week that the take-home doses are to be given, if applicable.

Sample Prescriptions	
Stabilized Dose with Witnessed Daily Ingestion	Stabilized Dose with Witnessed Daily Ingestion and Take Home Dose

- d) *Methadone Dosing.* Methadone dosing for the treatment of opioid dependency is generally divided into distinct phases:

Phase	Description
Initiation	When the first dose of methadone is given
Early Stabilization	The initial period when the dose is increased safely but rapidly enough to minimize significant withdrawal symptoms (0 – 2 weeks)
Late Stabilization	The period during which the stable dose is being approached (2 – 6 weeks)
Maintenance	When a stable dose has been reached (6 + weeks)

The physician should base the initial dose on the patient's underlying risk for methadone toxicity. A number of factors increase this risk, including:

- Recent benzodiazepine use
- Use of other sedating drugs
- Alcohol-dependent patients
- Over 60 years old
- Respiratory illnesses
- Taking drugs that inhibit methadone metabolism
- Lower opioid tolerance
- Decompensated hepatic disease
- Recent discharge from inpatient rehabilitation facility
- Recent incarceration

Since opioid tolerance is difficult to establish by history, if in doubt, it is safer to initiate on a lower dose.

Once initiated, dose increases should take place only after an in-person physician assessment. During the early and late stabilization phases, doses should only be increased for those patients who are experiencing significant opioid withdrawal symptoms. Physicians should generally be assessing patients at least once weekly during these phases.

During the maintenance phase (generally when the methadone dose is 80 mg or more), the physician should increase the dose by no more than 5-10 mg every 5-7 days. Physicians should be assessing patients once weekly when ongoing dose adjustments are occurring and less frequently thereafter as required.

The optimal dose range for most patients is 60-120 mg.

Patient Factors	Initial Dose	Dosing During Early and Late Stabilization Phases		Dosing During Maintenance Phase	
		Dose Increases	Frequency	Dose Increases	Frequency
Recent abstinence from opioids	10 mg or less	5 mg or less	Every 5 days or more	5-10 mg	Every 5-7 days
Higher risk for methadone toxicity	20 mg or less	5-10 mg	Every 3-5 days		
No risk factors or recent abstinence	30 mg or less	10-15 mg	Every 3-5 days		

Pharmacists should assess each methadone prescription to determine whether or not the dose falls within these recommended guidelines. Generally speaking, these criteria should be adhered to unless special circumstances such as concomitant acute pain treatment or pregnancy exist (see section 5.7) or if the patient's dose is being tapered due to voluntary or involuntary withdrawal from the program:

- i) For voluntary tapers, the dose should be reduced by 10% or less every one to four weeks
- ii) For involuntary tapers, the dose should be decreased by 5-10 mg every three to seven days until 50 mg is reached, then by no more than 5 mg every three to seven days.

If pharmacists see doses being prescribed outside of these guidelines or special circumstances, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

e) *Take-Home Doses.* Take-home doses are key to the success of treatment of opioid dependence. It has been demonstrated that not only do patients markedly reduce their use of heroin and cocaine when given take-home doses, but it also helps to prevent the decline in treatment outcomes over time. Patients strongly value take-home doses, and treatment retention rates are lower in clinics with restrictive take-home policies.

Typical Schedule: Patients are generally eligible for their first take-home dose if they meet specific criteria for clinical stability and have had at least three months in the methadone program and have demonstrated two months without substance use, as determined by history and urine drug screening.

Subsequent increases in take-home doses should occur no more often than every four weeks with evidence of clinical stability according to one of the following schedules:

Typical Take-Home Dose Schedules	
Schedule A	Schedule B
<ul style="list-style-type: none"> Start with one take-home dose per week. Increase by one take-home dose per week every four weeks, as appropriate, to a maximum of six take-home doses per week. Each additional take-home dose should be prescribed only after the patient has had at least four additional weeks without substance use. 	<ul style="list-style-type: none"> Start with two take-home doses on consecutive weekend days. After a further eight weeks free of substance use, take-home doses may be increased to one set of three consecutive days and one set of two consecutive days with an intervening witnessed dose. After an additional 12 weeks free of substance use, take-home doses may be increased to six take-home doses per week.

Accelerated Schedules: In certain exceptional cases where patients find it difficult to visit the pharmacy on a daily basis due to work, education or family commitments, the physician may decide it is appropriate to allow these patients to receive take-home doses on a more accelerated schedule. This should only occur if it is deemed that the patient is at low risk for misuse of their take-home doses (i.e., clinically stable, not currently addicted to other substances and no active mental illness) and has demonstrated at least four weeks without substance use, as determined by history and urine drug screening.

If these criteria are met, the physician may allow the patient their first take-home dose after two months in the program (instead of three) with subsequent increases in take-home doses every two to four weeks with continued evidence of clinical stability.

Only a minority of patients should require accelerated take-home doses. If pharmacists see take-home doses being prescribed outside of these criteria, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

Exceptional Circumstances: In situations where a patient is clinically stable, and receiving three to six take-home doses per week, the physician may allow for exceptional take-home doses to be given in the case of travel for work, vacation or family crisis, but only if a local pharmacy cannot be found. A 13-day dose is the maximum that may be given at a time in such special situations. The previous take-home dose schedule should be resumed after the period of exceptional take-home dose is completed. Generally the following criteria are advised (see table on next page):

If:	Then:
The patient has been treated for at least two months, not yet generally eligible for take-home doses, but is stable and is not considered high-risk for diversion	<ul style="list-style-type: none"> • Give take-home doses on compassionate grounds only, e.g., a personal crisis • Give no more than six take-home doses at a time.
The patient has been treated for at least two months, has had negative random urine drug screen (UDS) for at least four weeks and is approaching a stable methadone dose	<ul style="list-style-type: none"> • Give take-home doses for sound personal reasons only e.g., vacation / holidays / family matters • Give no more than six take-home doses.
The patient has demonstrated 12 months with no drug use, is clinically stable and already receiving three to six take-home doses per week.	<ul style="list-style-type: none"> • Give up to 13 take-home doses for travel purposes. • If more than 13 days of take-home doses is required, a second opinion with another physician is suggested.

If pharmacists see take-home doses being prescribed outside of these criteria, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

Suspending Take-Home Doses: In certain circumstances, it may be advisable for the physician to suspend the patient's take-home doses. This generally occurs in response to the patient having a relapse to substance use, or in the following situations:

- i) There is reasonably strong evidence that the patient has diverted their dose, or has tampered with their UDS.
- ii) The patient has missed three or more doses (except in unavoidable circumstances such as hospitalization).
- iii) The patient has become homeless or has unstable housing, and can no longer safely store their medication.
- iv) The patient is actively suicidal, cognitively impaired, psychotic, or is otherwise at high risk for misuse of their medication.
- v) The patient has recently been released from jail when incarcerated for prolonged periods of greater than three months.

In such situations, take-home doses should not be reinstated until stability can be re-established objectively via weekly UDS and other measures of clinical stability. This may take one month in patients whose drug use was sporadic and brief, and whose clinical stability is not significantly compromised, or up to two months or more in patients who have had a longer relapse with loss of clinical stability.

5.4 Dispensing the Prescription

- a) *Formulations.* With the availability of commercially-prepared, concentrated methadone solution products (e.g. Methadose™), dispensing compounded methadone is no longer permitted, except in exceptional circumstances, as it would be considered manufacturing in accordance with Health Canada's Policy on Manufacturing and Compounding Drug Products in Canada (http://www.hc-sc.gc.ca/dhp-mpps/compli-conform/gmp-bpf/docs/pol_0051-eng.php).

While there are a variety of these products on the market, in Newfoundland and Labrador, **pharmacists must dispense methadone using an unflavoured, commercially-prepared 10 mg/ml methadone solution.**

To determine the amount of concentrated solution to use, simply divide the methadone dose in milligrams by 10. For example, 80 mg methadone would require 8 mL of concentrated solution. Pharmacists should ensure that tools used to measure the concentrated solution have an accuracy of at least +/- 0.1 mL and are reserved for measuring methadone only.

NOTE: The only exception to the use of unflavoured, commercially-prepared 10 mg/ml methadone solution is when such a commercial product is not available. If this situation occurs, methadone stock solution may be compounded to a strength of 10 mg/ml, to ensure minimization of errors, and must be clearly labelled with the drug name, strength, use-by date and appropriate warning labels. If methadone is compounded, a compounding log must be established to record when methadone solutions are prepared, how much was prepared, and who prepared the product. (see sample Compounding Log in Appendix IV).

- b) *Storage.* Commercially-prepared methadone solutions are shelf-stable and, once opened, can generally be stored at room temperature for six months (Pharmacists should refer to appropriate product monographs for product-specific storage information). Diluted preparations should be stored in a secure refrigerator, a locked container in a standard refrigerator, or in another appropriate secure location until they are released to the patient.
- c) *Documentation.* All methadone doses must be individually recorded in the patient's medication profile. By processing each dose as an individual transaction, each dose label will accurately indicate the amount of methadone contained in each bottle and the patient's medication record will be clear with regard to the prescribed methadone dose, dispense dates and number of take-home doses provided.
- d) *Preparing Doses.*

NOTE: Equipment and devices used to measure methadone should be distinctively labelled and used exclusively for this purpose.

To prepare the dose, transfer the appropriate amount of concentrated solution to a container suitable for ingestion and dilute it with approximately 100 mL of an appropriate crystalline liquid (e.g., Kool-Aid or Tang). To avoid the potential for error, to optimize stability and sterility, and to avoid dose wastage, doses should only be prepared in advance for the next administration.

NOTE: Pharmacists should use best judgment to assign beyond-use dates for diluted products. Dates must be assigned based on the earliest expiry of the ingredients used or 14 days, whichever comes first. Dilution with fruit juices may require a shorter dating as an opened juice bottle may have a best before date that is earlier than 14 days.

Each witnessed dose must be individually labelled with:

- i) Patient's first and last name
- ii) Prescriber's full name or first initial and last name
- iii) Drug name (i.e. methadone or Methadose™)
- iv) Amount of drug (in mg) contained in the bottle to be consumed in a single dose
- v) Volume (in mL) of 10 mg/mL concentrated solution contained in the bottle
- vi) Local prescription number and DIS prescription number (if applicable)
- vii) Date of dispense
- viii) Quantity of medication (part-fills) remaining (if applicable)
- ix) Dispensing pharmacist's initials

Each take-home dose bottle must have a child- and tamper-resistant cap and must be individually labelled with:

- i) Pharmacy name, phone number and street address (if available, or, if not, a way of uniquely identifying the pharmacy location)
- ii) Patient's first and last name
- iii) Prescriber's full name or first initial and last name
- iv) Drug name (i.e. methadone or Methadose™)
- v) Amount of drug (in mg) contained in the bottle to be consumed in a single dose
- vi) Specific directions for use (such as "Consume the entire contents of this bottle on (insert date).")
- vii) Volume (in mL) of 10 mg/mL concentrated solution contained in the bottle
- viii) Local prescription number and DIS prescription number (if applicable)
- ix) Date of dispense
- x) Quantity of medication (part-fills) remaining (if applicable)
- xi) Dispensing pharmacist's initials
- xii) Cautionary labels:
 - Keep out of reach of children
 - Keep refrigerated
 - Special cautionary label for methadone such as:

"Methadone may cause serious harm to someone other than the intended patient. Not to be used by anyone other than the patient for whom it was intended. May be fatal to a child or adult."

OR

"May be toxic or lethal if ingested by a child or adult other than the intended patient. Accidental ingestion is considered a medical emergency and requires immediate medical attention."

5.5 Releasing the Prescription

- a) *Providing Witnessed Doses.* The pharmacist is required to witness the ingestion of the dose. This function may not be delegated to a pharmacy technician or any other member of the pharmacy team. Prior to releasing the witnessed dose to the patient, the pharmacist must:
 - i) positively identify the patient. If uncertain as to the patient's identity, photo identification should be requested.
 - ii) assess the patient for signs of intoxication or sedation (see section 5.6 below). If it is determined that the patient is intoxicated or sedated, it may be advisable to withhold the dose. If such determination is made, the physician must be notified immediately (see sample Prescriber Notification Form in Appendix V).
 - iii) review the patient's profile and Administration Log for notes, missed doses, documentation of returned bottles (if applicable), or any other applicable information.
 - iv) counsel the patient appropriately (for complete patient counselling information, see the relevant product monograph and information in required references).

Once it has been determined to be appropriate to release the witnessed dose, the pharmacist must:

- i) directly observe the patient ingesting the medication;
- ii) engage the patient in brief conversation to ensure the entire dose has been swallowed; and
- iii) appropriately document the dose on the Administration Log (see sample in Appendix VI).

- b) *Providing Take-Home Doses.* Prior to releasing any take-home doses, the pharmacist must witness the patient ingesting a dose. Following ingestion of the first dose, the patient may then be permitted to take the remaining doses home. When providing take-home doses to the patient, the pharmacist must:
- i) positively identify the patient. If uncertain as to the patient's identity, photo identification should be requested.
 - ii) review the patient's profile and Administration Log for notes, missed doses, documentation of returned bottles (if applicable), or any other applicable information.
 - iii) counsel the patient appropriately (for complete patient counselling information, see the relevant product monograph).
 - iv) appropriately document the provision of the take home doses on the Administration Log (see sample in Appendix VI).
- c) *Monitoring Compliance with Take-Home Doses.* There are several ways that pharmacists can monitor a patient's compliance with take-home doses.

Bottle Return: Pharmacists must advise patients that they should return their empty bottles with the original labels intact to the pharmacy for inspection and proper destruction at their next visit. Return of take-home dose bottles should be recorded on the patient's Administration Log. Bottles should never be reused, even for the same patient.

Take-Home Dose Audit: Patients should be advised that they may be asked at any time to return to the pharmacy with the remainder of their take-home doses and empty bottles. This procedure, known as a "take-home dose audit", may be used to deter patients from diverting their take-home doses. This audit may be initiated by either the physician or the pharmacist.

If there are issues of concern with the patient's compliance with their take-home doses or evidence of diversion, the pharmacist should notify the physician immediately (see sample Prescriber Notification Form in Appendix V).

5.6 Responding to Special Circumstances

- a) *Intoxication or Sedation.* To assess a patient for intoxication or sedation, consider their general demeanor and behaviour in comparison to what you know as their usual behaviour. If necessary,
- ask the patient to remove sunglasses and observe their eyes for pin-point pupils, alertness or sedation;
 - talk to the patient, asking questions to determine if they are slurring or incoherent;
 - ask the patient to walk to the counter and observe their gait.

If there is evidence of intoxication or sedation, the pharmacist should withhold the methadone dose from the patient to prevent a possible overdose. The physician must be notified immediately (see sample Prescriber Notification Form in Appendix V).

If the patient returns within eight hours of their originally scheduled witnessed ingestion, and the pharmacist is satisfied that the patient is no longer intoxicated or sedated, the pharmacist may give the patient the withheld dose. However, the pharmacist may not release any take-home doses until reauthorized by the physician.

- b) *Split Doses.* Split dosing may be used when treating patients with acute pain or who are pregnant. For more information, see section 5.7.
- c) *Missed Doses.* Missed doses may indicate a variety of problems, including relapse to alcohol or other drug use. Pharmacists **MUST** report **ANY** missed doses to the physician within 24 hours so that the physician can reassess the patient's clinical stability (see sample Prescriber Notification Form in Appendix V). Since a clinically significant loss of tolerance to opioids may occur within as little as three days without

methadone, the physician should reduce the methadone dose in patients who have missed three consecutive days. The dose can be rapidly increased once the response to the lower dose is assessed.

See the table below for more information on adjusting therapy for missed doses:

Phase of Treatment	Missed Doses	Action(s)	Dose Change(s)
Early Stabilization	1 day missed	<ul style="list-style-type: none"> No dose change 	<ul style="list-style-type: none"> Resume same dose Do not increase dose until 3 consecutive days at the same dose
	2 consecutive days missed	<ul style="list-style-type: none"> Patient should be reassessed by physician in person Remainder of prescription should be cancelled 	<ul style="list-style-type: none"> Restart at initial dose (10-30 mg) for at least 3 days Reassess after 3rd consecutive dose
Late Stabilization/Maintenance	1-2 days missed	<ul style="list-style-type: none"> No dose change Assess patient in 1-2 weeks to determine clinical stability 	<ul style="list-style-type: none"> Resume same dose
	3 consecutive days missed	<ul style="list-style-type: none"> Patient should be reassessed by physician in person and every 3-4 days thereafter if dose is increased daily Remainder of prescription should be cancelled 	<ul style="list-style-type: none"> Restart at 50% of regular dose or decrease to 30 mg Then increase dose by no more than 10 mg daily for maximum of 3 days, then reassess by day 3-4 Then increase dose by 10-15 mg every 3-5 days until 80 mg Then increase by 10 mg every 5-7 days for dose increases above 80 mg
	4 or more consecutive days missed	<ul style="list-style-type: none"> Patient should be reassessed by physician in person Remainder of prescription should be cancelled 	<ul style="list-style-type: none"> Restart at 30 mg or less Then increase dose by no more than 10-15 mg every 3-4 days until 80 mg Then increase by 10 mg every 5-7 days for dose increases above 80 mg

d) *Vomited Doses.* Replacement of a vomited methadone dose should only occur if the pharmacist or member of the pharmacy team directly observes the emesis within 30 minutes of ingestion.

In the case of a vomited methadone dose, the pharmacist must document the loss of the dose appropriately and notify the physician (see sample Prescriber Notification Form in Appendix V). The prescriber should be provided with as much information as possible (time dose was taken, time of emesis, etc.) to aid in their decision of whether or not to prescribe a replacement dose. Replacement doses should be no more than 50% of the original vomited dose.

A replacement dose should not be given until a new prescription is received from the prescriber.

For pregnant patients or patients with serious underlying conditions (e.g. cancer or HIV), the physician should be contacted as soon as possible as he or she may decide to prescribe a replacement dose even if the pharmacist or staff did not directly observe the emesis.

5.7 Special Patient Populations

- a) *Pregnancy.* Pregnancy provides a “window of opportunity” to motivate substance using women to make changes in their lives. MMT during pregnancy offers many benefits including improved prenatal care, nutritional status and social stability leading to increased likelihood of maternal custody, as well as, reduced incidence of pre-term delivery, low birth weight and infant mortality.

Ideally, in pregnant women, methadone would be initiated on an in-patient basis to allow for consistent monitoring. Realistically, this is not always possible and should not be seen as a barrier to treatment.

While dose initiation is more complex and does not always follow the typical schedule during pregnancy, patients who are already taking methadone prior to conception can generally continue on their pre-pregnancy dose during the first and second trimesters. Small increases in doses may be warranted during the third trimester.

Physicians may split the methadone dose in some cases, as split dosing during pregnancy has been shown to be related to lower withdrawal symptoms and less fetal distress.

For more information on treating patients with methadone while pregnant, see section 12. of the CPSNL Standards and Guidelines.

- b) *Pain Management.* Since patients taking methadone are often tolerant to the analgesic effects of opioids, if they experience pain requiring opioids, they may require higher or more frequent doses than non-tolerant patients.

While non-opioid treatments should be considered first-line for mild or moderate pain, for eligible patients with acute pain that warrants short-term opioid therapy, physicians may temporarily split the methadone dose with an additional 10-15 mg evening dose, or prescribe opioids in addition to methadone.

If opioids are prescribed for acute pain, the physician should choose an opioid that the patient has not misused in the past (preferably codeine or tramadol first, followed by morphine, if necessary), instruct that the opioid be dispensed in small amounts and limit the prescription to only the number of days absolutely necessary.

6) Practice Standards for Participation in Opioid-Dependence Treatment with Buprenorphine-Naloxone

6.1 Collaboration Between the Pharmacist and the Prescriber

- a) *Verbal Discussion.* While not required by the CPSNL Standards and Guidelines, it is strongly encouraged that the physician and pharmacist have a verbal discussion outlining the details of the physician's treatment agreement with the patient along with his or her expectations regarding missed doses and intoxication, among other things, prior to dispensing buprenorphine-naloxone to the patient. This may or may not be followed up with documentation of these issues being sent to the pharmacist by the physician.

6.2 Establishing the Pharmacist – Patient Relationship

- a) *Verbal Discussion.* Pharmacists should arrange for an initial meeting with the patient to discuss the services that they will provide, along with the obligations and expectations of both the pharmacy staff and the patient within this relationship. The patient should be given the opportunity to ask questions and relevant written information should be made available to supplement the discussion.
- b) *Written Agreement.* A written Pharmacy-Patient Agreement serves to outline the roles, expectations and obligations of both parties and can go a long way to prevent and/or handle any misunderstandings that may occur in the future. It is strongly recommended that such an agreement be developed by the pharmacy and read and signed by both the patient and the pharmacist prior to buprenorphine-naloxone for opioid dependence being dispensed. (See Appendix VII for a template Pharmacy-Patient Agreement for Buprenorphine-Naloxone Maintenance Treatment).

6.3 Assessing the Prescription

- a) *Tamper Resistant Prescription Drug Pad Program Form.* In NL, all prescriptions for buprenorphine must be written on the TRPP form, as required by the Tamper Resistant Prescription Drug Pad Program. This form is required regardless of whether the prescription is written by an in-province or out-of-province prescriber.

For more information on this program and its requirements, visit the Department of Health and Community Services website at http://www.health.gov.nl.ca/health/prescription/hcp_tamperresistantdrugpad.html.

- b) *Required Information.* The prescription must be appropriately signed and dated by the physician and also specify:
- The daily dose of buprenorphine-naloxone in milligrams, written in both numbers and words
 - The start date and end date of the prescription
 - The total number of witnessed doses, written in both numbers and words and the days of the week that doses are to be witnessed
 - If take-home doses are authorized, the number of take-home doses per week and the days of the week that the take-home doses are to be given.
- c) *Buprenorphine-Naloxone Dosing.* Buprenorphine-naloxone dosing is based on the buprenorphine component and tends to be less variable than methadone dosing overall. Patients are generally given an induction dose when they are in a period of at least moderate opioid withdrawal and are then steadily increased according to the patient's needs over a period of a few days.

Phase	Initial Dose	Dose Increases	Maximum Dose
Induction	Single 2-4 mg dose	An additional 4 mg dose may be administered on the same day depending on the individual patient's requirements.	8 mg on Day 1

		Second dose should be given only after physician assessment and not sooner than 3 hours after the initial dose.	
Maintenance	A dose equivalent to the total dose given on Day 1	Dose can be increased by 2-8 mg every 3-5 days to an average dose of 8-12 mg/day	24 mg/day

Pharmacists should assess each buprenorphine-naloxone prescription to determine whether or not the dose falls within these recommended guidelines. Generally speaking, these criteria should be adhered to unless special circumstances exist. Once the patient is at a stable maintenance dose, consideration may be given to alternate day dosing (i.e. 16 mg every other day, instead of 8 mg daily), but these situations should be the exception and evaluated on a case-by-case basis.

If pharmacists see doses being prescribed outside of these guidelines or special circumstances, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

- d) *Take-Home Doses.* Take-home doses are key to the success of treatment of opioid dependence. It has been demonstrated that not only do patients markedly reduce their use of heroin and cocaine when given take-home doses, but it also helps to prevent the decline in treatment outcomes over time. Patients strongly value take-home doses, and treatment retention rates are lower in clinics with restrictive take-home policies.

Typical Schedule: In general, patients are eligible for their first take-home dose of buprenorphine-naloxone if they meet specific criteria for clinical stability, have had at least two months of daily witnessed dosing and have demonstrated two months without substance use, as determined by history and urine drug screening. There should be a gradual increase in the number of weekly take-home doses (starting with just weekends and holidays) up to a suggested maximum of one to two weeks of consecutive take-home doses dispensed between observed doses.

Accelerated Schedule: While the Centre for Addictions and Mental Health (CAMH) guidelines do allow for the physician to prescribe take-home doses earlier than two months after treatment is initiated, they also advise that this would be considered “off-label” prescribing and the patient must be made aware of this, as well as, of the additional risks of starting take home dosing earlier than normal.

Again, this situation should be the exception and evaluated on a case-by-case basis. If pharmacists see take-home doses being prescribed outside of these criteria, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

Exceptional Circumstances: There may occasionally be circumstances where the physician allows for exceptional take-home doses to be given in the case of travel for work, vacation, or family crisis. The previous take-home dose schedule should be resumed after the period of exceptional take-home dose is completed.

If pharmacists see take-home doses being prescribed outside of these criteria, they should consult with the prescribing physician and document the rationale for the deviation in the patient record.

Suspending Take-Home Doses: In certain circumstances, it may be advisable for the physician to suspend the patient’s take-home doses. This generally occurs in response to the patient having a relapse to substance use, or in the following situations:

- i) There is reasonably strong evidence that the patient has diverted their dose, or has tampered with their UDS.
- ii) The patient has missed three or more doses (except in unavoidable circumstances such as hospitalization).

- iii) The patient has become homeless or has unstable housing, and can no longer safely store their medication.
- iv) The patient is actively suicidal, cognitively impaired, psychotic, or is otherwise at high risk for misuse of their medication.
- v) The patient has recently been released from jail when incarcerated for prolonged periods of greater than three months.

In such situations, take-home doses should not be reinstated until stability can be re-established objectively via weekly UDS and other measures of clinical stability. This may take one month in patients whose drug use was sporadic and brief, and whose clinical stability is not significantly compromised, or up to two months or more in patients who have had a longer relapse with loss of clinical stability.

6.4 Dispensing the Prescription

- a) *Formulations.* Buprenorphine-naloxone (Suboxone® and generics) is available as a sublingual tablet with either 2 mg of buprenorphine and 0.5 mg of naloxone or 8 mg of buprenorphine and 2 mg of naloxone.
- b) *Preparing Witnessed Doses.* Buprenorphine-naloxone should be dispensed in a light-resistant vial labelled with:
 - i) Patient's first and last name
 - ii) Prescriber's full name or first initial and last name
 - iii) Drug name (i.e. buprenorphine-naloxone or Suboxone®)
 - iv) Amount of drug (in mg or # of tablets) contained in the vial to be consumed in a single dose
 - v) Local prescription number and DIS prescription number (if applicable)
 - vi) Date of dispense
 - vii) Quantity of medication (part-fills) remaining (if applicable)
 - viii) Dispensing pharmacist's initials
- c) *Preparing Take Home Doses.* Take-home doses of buprenorphine-naloxone should be dispensed in a light-resistant vial with a child-resistant cap and labelled with:
 - i) Pharmacy name, phone number and street address (if available, or, if not, a way of uniquely identifying the pharmacy location)
 - ii) Patient's first and last name
 - iii) Prescriber's full name or first initial and last name
 - iv) Drug name (i.e. buprenorphine-naloxone or Suboxone®) and strength
 - v) Total number of tablets in the vial
 - vi) Specific directions for use (such as "Take X tablets on (insert date or days of week).")
 - vii) Local prescription number and DIS prescription number (if applicable)
 - viii) Date of dispense
 - ix) Quantity of medication (part-fills) remaining (if applicable)
 - x) Dispensing pharmacist's initials
 - xi) Cautionary labels:
 - Keep out of reach of children
 - Special cautionary label such as: *"May be toxic or lethal if ingested by a child or adult other than the intended patient. Accidental ingestion is considered a medical emergency and requires immediate medical attention."*

6.5 Releasing the Prescription

- a) *Providing Witnessed Doses.* The pharmacist is required to witness the ingestion of the dose. This function may not be delegated to a pharmacy technician or any other member of the pharmacy team. Prior to releasing the witnessed dose to the patient, the pharmacist must:
- i) positively identify the patient. If uncertain as to the patient's identity, photo identification should be requested;
 - ii) assess the patient for signs of intoxication or sedation (see section 6.6). If it is determined that the patient is intoxicated or sedated, it may be advisable to withhold the dose. If such determination is made, the physician must be notified immediately (see sample Prescriber Notification Form in Appendix VI);
 - iii) review the patient's profile and Administration Log for notes, missed doses, documentation of returned vials (if applicable), or any other applicable information; and
 - iv) counsel the patient appropriately (for complete patient counselling information, see the relevant product monograph).

Once it has been determined to be appropriate to release the witnessed dose, the pharmacist must:

- i) prepare the buprenorphine-naloxone dose by placing the tablets in a disposable single-use cup , taking care to avoid skin contact.
 - ii) directly observe the patient ingesting the dose. The patient should be instructed to place the contents of the cup under the tongue and stay within the sight of the pharmacist observing the dose since it can take 1-10 minutes for buprenorphine-naloxone tablets to dissolve completely;
 - iii) ask the patient to open their mouth and lift up their tongue to ensure the entire dose has dissolved; and
 - iv) appropriately document the dose on the Administration Log (see sample in Appendix VI).
- b) *Providing Take-Home Doses.* Prior to releasing any take-home doses, the pharmacist must witness the patient ingesting a dose. Following ingestion of the first dose, the patient may then be permitted to take the remaining doses home. When providing take-home doses to the patient, the pharmacist must:
- i) positively identify the patient. If uncertain as to the patient's identity, photo identification should be requested.
 - ii) review the patient's profile and Administration Log for notes, missed doses, documentation of returned vials (if applicable), or any other applicable information.
 - iii) counsel the patient appropriately (for complete patient counselling information, see the relevant product monograph).
 - iv) appropriately document the provision of the take-home doses on the Administration Log (see sample in Appendix VI).

- c) *Monitoring Compliance with Take-Home Doses.* There are several ways that pharmacists can monitor a patient's compliance with take-home doses.

Bottle Return: Patients should be advised to return their empty vials with the original labels intact to the pharmacy for inspection and proper destruction at their next visit. Return of take-home dose bottles should be recorded on the patient's Administration Log. These vials should not be reused, even for the same patient.

Take-Home Dose Audit: Patients should be advised that they may be asked at any time to return to the pharmacy with the remainder of their take-home doses and empty vials. This procedure, known as a "take-home dose audit", may be used to deter patients from diverting their take home doses. This audit may be initiated by either the physician or the pharmacist.

If there are issues of concern with the patient's compliance with their take-home doses or evidence of diversion, the pharmacist should notify the physician immediately (see sample Prescriber Notification Form in Appendix V).

6.6 Responding to Special Circumstances

- a) *Intoxication or Sedation.* To assess a patient for intoxication or sedation, consider their general demeanor and behaviour in comparison to what you know as their usual behaviour. If necessary,
- ask the patient to remove sunglasses and observe their eyes for pin-point pupils, alertness or sedation;
 - talk to the patient, asking questions to determine if they are slurring or incoherent;
 - ask the patient to walk to the counter and observe their gait.

If there is evidence of intoxication or sedation, the pharmacist should withhold the dose from the patient to prevent a possible overdose. The physician must be notified immediately (see sample Prescriber Notification Form in Appendix V).

If the patient returns within eight hours of their originally scheduled, witnessed ingestion and the pharmacist is satisfied that the patient is no longer intoxicated or sedated, the pharmacist may give the patient the withheld dose. However, the pharmacist may not release any take-home doses until reauthorized by the physician.

- b) *Missed Doses.* Missed doses may indicate a variety of problems, including relapse to alcohol or other drug use. Pharmacists **MUST** report **ANY** missed doses to the physician within 24 hours so that the physician can reassess the patient's clinical stability (see sample Prescriber Notification Form in Appendix V). If a patient has missed five days or less of buprenorphine-naloxone, they may resume their previous dose. If the patient misses more than five days, the physician may adjust the dose according to the following recommendations:

Buprenorphine Dose	Number of Consecutive Days Missed	New Starting Dose
> 8 mg	> 7 days	4 mg
> 8 mg	6-7 days	8 mg
6-8 mg	6 or more days	4 mg
2-4 mg	6 or more days	2-4 mg

Special consideration should be given to missed doses in patients who are on an alternate day dosing schedule.

7) Ensuring Continuity of Care

7.1 Secondary Pharmacy

If a pharmacy has a patient who requires daily witnessed ingestion, but is not normally open seven days a week, the pharmacist must work with the physician to ensure that the patient is still able to acquire their doses on the days the pharmacy is closed.

This may include collaboration with another community or hospital pharmacy, opening at pre-arranged selected times on the day(s) the pharmacy is otherwise closed and/ or authorization for a take-home dose on selected days that the pharmacy is closed. However, take-home doses should not be prescribed for this purpose, if the criteria for take-home doses are not otherwise met.

7.2 Hospitalization or Incarceration

During a hospital inpatient stay, or confinement to a correctional setting, it is the responsibility of the institutional staff to ensure the continuity of treatment for opioid dependence through its own pharmacy or by arrangement with the patient's community pharmacy. A pharmacist at the hospital should contact the patient's usual pharmacy at the time of admission to confirm:

- the patient's participation in therapy
- the patient's dose
- the date and time of the last dose

In a hospital or correctional facility, methadone or buprenorphine-naloxone should be administered in accordance with policies and procedures of the applicable regional health authority or facility.

For care of hospital in-patients, if there is no physician on staff authorized to prescribe opioid dependence treatment, a temporary exemption may be issued by Health Canada to the physician responsible for the patient's treatment at the hospital or other institution. It must be noted that only practitioners are eligible to receive a temporary exemption (e.g. medical residents may not receive an exemption). The exemption is granted for the period of the patient's hospitalization (up to 60 days) and expires when the patient is discharged from the hospital or in 60 days, whichever is less. Should the patient be hospitalized longer than 60 days, the authorization may be extended. A physician with a temporary exemption may not start new patients on methadone. A temporary exemption is only for patients who are already on methadone before hospitalization.

The attending physician may obtain a temporary exemption by contacting the Office of Controlled Substances at:

Phone: (613) 946-5139

Fax: (613) 952-2196

e-mail: exemption@hc-sc.gc.ca

The following information must be provided:

- Full name and Licence number of physician
- Telephone number of physician
- Name and address of hospital
- Telephone number of hospital pharmacy
- Name of patient
- Indication for methadone (dependency or analgesia)
- Daily dose of methadone
- Date of first dispensing dose

Before discharge, a pharmacist at the patient's community pharmacy should be contacted by hospital staff and notified of the patient's discharge and the details of the patient's last methadone dose in order to ensure the appropriate continuation of outpatient pharmacotherapy. If this contact does not occur, the community pharmacist should contact a pharmacist at the facility to confirm the details of the last dose prior to dispensing any methadone to the patient.

Upon discharge, arrangements for continued provision of medication should be part of the discharge plan.

8) **Documentation and Retention Requirements**

All documentation related to these Standards, including prescriptions, forms and communications must be retained in the pharmacy in a readily retrievable format for a minimum of ten years.

Appendix I

Comparison of Methadone and Buprenorphine for Treatment of Opioid Dependence

What is methadone?	What is buprenorphine?
<p><u>General</u></p> <ul style="list-style-type: none"> • A full opioid agonist with actions at the μ (μ) opioid receptor • No ceiling effect <p><u>Pharmacology</u></p> <ul style="list-style-type: none"> • Dose continues to accumulate over many days • Onset of action: 3 hours • Peak effects: 2 - 4 hours • Elimination half-life: 25 hours (5 - 130 hours) • Steady state: 2 - 9 days <p><u>Administration & Availability</u></p> <ul style="list-style-type: none"> • Available as a 10 mg/ml oral concentrate in a red, cherry-flavoured hypertonic syrup and as a dye-free, sugar-free, unflavoured clear concentrate. • Formulations allow for patient preferences in taste, and can accommodate for those with dye allergies • Titration to desired response is possible over a wide range of doses <p><u>Advantages</u></p> <ul style="list-style-type: none"> • No ceiling effects can mean better efficacy profile in those addicted to higher doses of opioid • Flexible dosing • Long history of use and clinical experience • Many resources for guidance on proper use • Considered a safer option to buprenorphine-naloxone in pregnancy <p><u>Disadvantages</u></p> <ul style="list-style-type: none"> • Titration to response may take longer than buprenorphine • Poses a greater danger of toxicity during the initiation phase • Level of respiratory depression or sedation does not have ceiling effect and therefore may be fatal in overdose • More clinically significant drug interactions; increased need for close monitoring and appropriate prescribing • Requires routine ECG and monitoring • Greater toxicity to children and those who are opioid naïve; carry doses pose a greater danger to the public and require close monitoring and communication for proper storage • Difficult to wean completely off 	<p><u>General</u></p> <ul style="list-style-type: none"> • A partial opioid agonist at the μ (μ) receptor • Ceiling effect; effectiveness plateaus once serum level is reached • Product for opioid dependence (Suboxone® or generic equivalent) includes naloxone which has no pharmacologic purpose but is included to deter against diversion and injection abuse <p><u>Pharmacology</u></p> <ul style="list-style-type: none"> • Longer half-life than methadone so may be dosed every other day once stabilized • Onset of action: 30 - 60 minutes • Peak effects: 1 - 4 hours • Elimination half-life: 37 hours (20 - 72 hours) • Steady state: 7 - 10 days <p><u>Administration & Availability</u></p> <ul style="list-style-type: none"> • Available in 2mg and 8mg unscored sublingual tablets • Dose range less flexible, ranging from 2 - 24 mg daily • Witnessed dosing can be prolonged as it can take from 2 - 10 minutes for sublingual tablet to dissolve <p><u>Advantages</u></p> <ul style="list-style-type: none"> • Partial agonist, therefore lower abuse potential • Ceiling effects on respiratory depression means better safety profile • Can be easier to prescribe; dosing is simple; rapid escalation to the maximal dose • Enhanced convenience; may allow for an increased number of carry doses due to reduced risk • Longer half-life means possibly more moderate withdrawal symptoms when weaning someone completely off treatment. • Lower prevalence of drug interactions than methadone • Less toxic; carry doses pose less danger to the public <p><u>Disadvantages</u></p> <ul style="list-style-type: none"> • Efficacy is limited by its ceiling effect; may be inadequate to control withdrawal symptoms in those dependent on higher doses of opioids • Generally more expensive than methadone • Newer drug for addiction; limited experience with use and/or long term safety • Not recommended in pregnancy due to the naloxone component • Not recommended for use while breastfeeding

Appendix II
Methadone Maintenance Treatment
Copy of Sample Physician-Pharmacy Agreement

Doctor's Name and Clinic
Address
Telephone
Facsimile

Dear Pharmacist,

Our patient has requested to attend your pharmacy for Methadone Maintenance Treatment. We encourage an active communication between pharmacist and physician.

I have already discussed the following safety measures, methadone dispensing practices, and clinic policies with the patient. Please feel free to contact me to discuss any of these matters or any further suggestions that your team may have for this patient's clinical care.

You may call/page me at _____. (PLEASE DO NOT GIVE THIS
PAGER/PHONE NUMBER TO THE PATIENT.)

- Patients are required to drink methadone dispensed in approximately 100 ml orange Tang or other crystalline juice in front of the pharmacist. You or a member of your team must witness ingestion of methadone every day for patients receiving daily dispensing and on the day that patients pick up their doses for patients receiving take-home doses. Ask the patient to speak after their drink to ensure that has been swallowed.
- The pharmacy team shall inform the methadone physician of any information or observed evidence of diversion of methadone.
- The pharmacist shall inform the methadone physician of missed methadone doses by the patient.
- If the patient misses three (3) or more doses in a row, withhold the methadone dose from the patient to prevent an overdose. The methadone physician must reassess the patient before methadone is restarted.
- If there is any evidence of intoxication, sedation or impairment (slurred speech, stumbling gait, disorientation), the pharmacist must withhold the methadone dose from the patient to prevent a possible overdose. The pharmacy team must contact the methadone physician to inform them of the observation of concern. If the patient returns within eight (8) hours of their originally scheduled, witnessed ingestion, and the pharmacist is satisfied that the patient is no longer intoxicated, sedated or impaired, the pharmacist may give the patient the withheld dose. However, the pharmacist may not release any take-home doses until reauthorized by the physician.
- If the pharmacist observes evidence of an overdose, he or she must advise the patient to receive urgent medical care. The pharmacist may call 911 for transport to hospital. The

pharmacist will contact the physician directly to inform them of the overdose and treatment directives.

- Dispense take-home doses in childproof bottles. Patients are advised to store any take-home doses in a locked metal box to ensure community safety (i.e., to avoid misplacement/loss and consumption of methadone by someone other than to whom it is prescribed). The pharmacist may request that the patient present the locked box prior to issuing take-home doses.
- Pharmacists may replace any doses of methadone vomited only if the pharmacist or a member of the pharmacy team has witnessed the vomiting within 30 minutes of ingestion. The replacement dose should be no more than 50% of the original vomited dose. The pharmacist should inform the methadone provider regarding the vomited dose.
- The start and end date recorded on the prescription are the first day and the last day the patient is authorized to receive a dose for that prescription. The pharmacist must not dispense any methadone from that prescription after the end date, regardless of the fact that there may be doses remaining on that prescription.
- The physician may authorize a patient to receive take-home doses based on their clinical stability. Providing take-home doses to a patient before they are clinically stable puts them and the public at risk of overdose and diversion. Providing take-home doses for patients because the pharmacy is closed is a last resort when all other steps outlined in the *NLPB MMT Standards of Practice* and the *CPSNL Methadone Maintenance Treatment Handbook* have been exhausted, and then only in accordance with these documents.

(Note: Physician and pharmacist may agree on additional terms, provided they are not contrary to the CPSNL MMT Standards and Guidelines).

Sincerely,

/signature/

Name of Physician
CPSNL License Number

Appendix III
Methadone Maintenance Treatment
Pharmacy-Patient Agreement Form

This is an agreement between

Pharmacy Name

Patient Name

for the provision of services related to the treatment of opioid dependence.

As your pharmacy provider, we are committed to your success to overcome your opioid dependency. This agreement highlights our mutual expectations while you are using our pharmacy services.

We agree to provide you with:

- Professional, non-judgmental services that recognize your rights to respect and personal dignity.
- Access to trained professionals who are competent in medication-assisted opioid dependence treatment to answer your questions and concerns about your treatment(s).
- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.
- Privacy and confidentiality with your health information. We will only share information with your consent or if required by law.
- Ongoing monitoring of your response and progress with treatment while you remain under the pharmacy's care.

As a patient in our pharmacy, we also have certain expectations for you to meet. By signing this agreement, you agree to the following:

- I understand that a valid prescription is required before any methadone will be dispensed and that it is my responsibility to make sure the prescription does not expire.
- I realize that I may be asked to present identification before receiving my first dose from the pharmacy and when receiving methadone from any new pharmacist on staff.
- I will present at the pharmacy for my daily witnessed dose between the hours of _____ and _____ daily (should be a consistent time each day).
- I understand that by missing a day, I have missed a dose and this will not be made up and will be reported to my physician.
- I understand that methadone doses will be diluted with Tang or a similar product, unless otherwise specified by the physician on each prescription.
- I understand that I will be observed swallowing my witnessed dose and that this will be confirmed by speaking to the pharmacist after swallowing the dose.
- I will return the container used to drink my methadone dose in the pharmacy.
- I understand I may not be given my medication if I am under the influence of other substances and that this will be reported to my physician.
- If I have been authorized to receive take home doses:
 - I will pick up my take home doses in person and sign, confirming that I have received and take responsibility for the correct number of take home doses.
 - I will store all take home doses safely and securely in my home, preferably in a locked box, to ensure there is no chance of accidental ingestion.

- I will take each dose as prescribed, as indicated by the label on the bottle.
 - I will not stockpile, sell or otherwise divert my take home doses.
 - I will save all my bottles with their original labels left intact and bring them back to the pharmacy for verification and proper disposal.
 - I am aware that my pharmacist may request me to come in for a random check during the period and will require me to bring in all my full and empty bottles at such a time.
 - I understand that lost or missing take home doses will not be replaced without a prescription from my physician.
 - I understand that the pharmacist may openly communicate with other health professionals directly involved in my care (including but not limited to other pharmacists, physicians or nurses) concerning any aspect of the treatment of my opioid dependence.
 - I understand that, unless witnessed by a member of the pharmacy team, vomited doses will not be replaced without a prescription from my physician.
 - If I am required to pay for my methadone, I will pay at the time I receive the dose. Failure to pay for my doses may result in discharge from the program.
 - I understand that, at any time, the pharmacist may refuse to dispense my medication for any of the following reasons:
 - **Threats** – the patient, family member or friend has threatened the safety or well-being of any staff member or another patient or pharmacy customer by oral or written action
 - **Disruptive Behaviour** – the patient, family member or friend has engaged in disruptive behaviour on the pharmacy premises
 - **Violent Behaviour** – the patient, family member or friend has engaged in violent behaviour towards a staff member, patient or another person
 - **Illegal Activity** – the patient, family member or friend has engaged in illegal activity (for example, theft) on the premises
 - **Diversion of Methadone** – the patient has diverted, or allowed to be diverted, any part of their dose
 - **Missed Doses** – The patient has failed to pick up their dose for three consecutive days (unless alternative arrangements for pick-up have been made or there is convincing evidence that the failure to pick-up was beyond their control)
- I understand and agree to comply with these requirements.***
- I understand that if I do not comply with these requirements, I may be asked to find an alternative pharmacy.***

Patient Signature

Date

Pharmacist Signature

Date

Appendix V
Medication-Assisted Opioid Dependence Treatment
Prescriber Fax Notification Form

To: _____
Prescriber Name _____ Fax # _____

Date: _____

Re: _____
Patient Name _____ MCP # _____

From: _____
Pharmacy Name _____ Pharmacist Name _____
_____ Phone # _____ Fax # _____

- Type of Incident:**
- The patient missed his/her dose on (date): _____
 - The patient vomited his/her dose on (date): _____
 - Emesis was witnessed by a pharmacist or another member of the pharmacy team; suggest that prescription for replacement dose of _____ mg be faxed to the pharmacy.
 - Emesis was not witnessed by a pharmacist or another member of the pharmacy team.
Recommended action: _____
 - The patient reported a lost or stolen take home dose on (date): _____
 - The patient was refused his/her dose on (date): _____ due to the fact that he/she presented at the pharmacy in an intoxicated or sedated state.

Additional Details: _____

(if applicable) _____

Follow-up Plan: _____

(if applicable) _____

Appendix VII
Buprenorphine-Naloxone Maintenance Treatment
Pharmacy-Patient Agreement Form

This is an agreement between

Pharmacy Name

Patient Name

for the provision of services related to the treatment of opioid dependence.

As your pharmacy provider, we are committed to your success to overcome your opioid dependency. This agreement highlights our mutual expectations while you are using our pharmacy services.

We agree to provide you with:

- Professional, non-judgmental services that recognize your rights to respect and personal dignity.
- Access to trained professionals who are competent in medication-assisted opioid dependence treatment to answer your questions and concerns about your treatment(s).
- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.
- Privacy and confidentiality with your health information. We will only share information with your consent or if required by law.
- Ongoing monitoring of your response and progress with treatment while you remain under the pharmacy's care.

As a patient in our pharmacy, we also have certain expectations for you to meet. By signing this agreement, you agree to the following:

- I understand that a valid prescription is required before any medication will be dispensed and that it is my responsibility to make sure the prescription does not expire.
- I realize that I may be asked to present identification before receiving my first dose from the pharmacy and when receiving methadone from any new pharmacist on staff.
- I will present at the pharmacy for my daily witnessed dose between the hours of _____ and _____ daily (should be a consistent time each day).
- I understand that by missing a day, I have missed a dose and this will not be made up and will be reported to my physician.
- I understand that I will be observed ingesting my witnessed dose and that this will be confirmed by the pharmacist asking to see the inside of my mouth and under my tongue after taking the dose.
- I will return the container used to take my dose in the pharmacy.
- I understand I may not be given my medication if I am under the influence of other substances and that this will be reported to my physician.
- If I have been authorized to receive take home doses:
 - I will pick up my take home doses in person and sign, confirming that I have received and take responsibility for the correct number of take home doses.
 - I will store all take home doses safely and securely in my home, preferably in a locked box, to ensure there is no chance of accidental ingestion.

- I will take each dose as prescribed, as indicated by the label.
- I will not stockpile, sell or otherwise divert my take home doses.
- I will save all my vials with their original labels left intact and bring them back to the pharmacy for verification and proper disposal.
- I am aware that my pharmacist may request me to come in for a random check during the period and will require me to bring in all my full and empty vials at such a time.
- I understand that lost or missing take home doses will not be replaced without a prescription from my physician.
- I understand that the pharmacist may openly communicate with other health professionals directly involved in my care (including but not limited to other pharmacists, physicians or nurses) concerning any aspect of the treatment of my opioid dependence.
- If I am required to pay for my medication, I will pay at the time I receive the dose. Failure to pay for my doses may result in discharge from the program.
- I understand that, at any time, the pharmacist may refuse to dispense my medication for any of the following reasons:
 - **Threats** – the patient, family member or friend has threatened the safety or well-being of any staff member or another patient or pharmacy customer by oral or written action
 - **Disruptive Behaviour** – the patient, family member or friend has engaged in disruptive behaviour on the pharmacy premises
 - **Violent Behaviour** – the patient, family member or friend has engaged in violent behaviour towards a staff member, patient or another person
 - **Illegal Activity** – the patient, family member or friend has engaged in illegal activity (for example, theft) on the premises
 - **Diversion of Medication** – the patient has diverted, or allowed to be diverted, any part of their dose
 - **Missed Doses** – The patient has failed to pick up their dose for three consecutive days (unless alternative arrangements for pick-up have been made or there is convincing evidence that the failure to pick-up was beyond their control)

I understand and agree to comply with these requirements.

I understand that if I do not comply with these requirements, I may be asked to find an alternative pharmacy.

Patient Signature

Date

Pharmacist Signature

Date