



# OATP

Opioid Agonist  
Therapy Program

## STANDARDS AND GUIDELINES

*for the Treatment of Opioid Use Disorder*

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College of Physicians and Surgeons of Alberta's document

*Alberta Methadone Maintenance Treatment –  
Standards and Guidelines for Dependence*

and has been adopted and liberally adapted with permission  
to provide support to methadone-prescribing physicians in Saskatchewan.

The 2021 revision is based heavily upon Centre for Addiction and Mental Health's  
*Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder.*

Treating opioid use disorder with Slow-Release Oral Morphine or pharmaceutical safe supply  
is beyond the scope of this document and further guidance will be available in subsequent  
documents. Until such time, these options should only be considered when there is shared  
care with an addiction expert and all other evidence-based options (e.g. buprenorphine,  
methadone) have been exhausted.

This document was revised in 2021 because of the changing toxic drug supply which has  
caused countless tragic losses of life.

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## INTRODUCTION

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The *Saskatchewan Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder* guides physicians and other healthcare practitioners in the prescribing of buprenorphine/naloxone or methadone to treat patients diagnosed with opioid use disorder.

While the audience for this document is physicians, it is acknowledged that there are other health professionals involved in the care of patients with opioid use disorder. This document is not intended to be a comprehensive manual, nor is it expected to replace sound clinical judgment. Physicians are encouraged to consult with an expert in Opioid Agonist Therapy (OAT) or addiction medicine as required.

The College of Physicians and Surgeons of Saskatchewan (CPSS) plays a leadership role in establishing standards and best practices in medicine including this very complex area of practice. The CPSS Regulatory Bylaws contain information related to practice standards for Saskatchewan physicians. Bylaw 18.1 describes the Prescription Review Program (PRP) which applies to both methadone and buprenorphine. Bylaw 19.1 describes the standards for prescribing of buprenorphine and/or methadone for opioid use disorder.

The main objective of this document is to increase or maintain the safety of patients receiving treatment for opioid use disorder. It is also hoped that the standards and guidelines raise awareness of opioid use disorder with physicians and the healthcare community, and support and encourage physicians to consider OAT in the treatment of patients in their clinic or as a part of their general practice.

These standards and guidelines were developed to support:

- (a) Experienced OAT prescribers (initiating prescribers) with a focused OAT practice,
- (b) Community-based prescribers (maintaining prescribers) who take on stable OAT patients as a part of their regular practice, and
- (c) Temporary prescribers of methadone or buprenorphine/naloxone who are prescribers that temporarily care for an OAT patient in a hospital or corrections facility.

Standards and guidelines for OAT are intended to enhance patient care by improving the consistency of and access to safe clinical OAT management, and patient and community health and safety.

These standards and guidelines are based on multiple sources of evidence on the safe and effective management of opioid use disorder. This document is based on data obtained from best practice guidelines and research in the field of addictions medicine, as well as clinical experience from respected authorities and individual professionals in the field.

This Saskatchewan-based document draws heavily on the standards and guidelines recently developed by the College of Physicians and Surgeons of Alberta. We thank the College of Physicians and Surgeons of Alberta for the thoroughness of their work, and for permission to use it as a foundation for our own guideline.

## The Difference Between Standards and Guidelines

**Standards** define a minimum acceptable level of care to ensure patient safety. Standards are a mandatory requirement.

**Guidelines** provide direction that "should" be followed when managing specific issues. In OAT, guidelines provide direction and recommendations for effectiveness and optimal patient care. Guidelines assist Initiating, Maintaining and Temporary Prescribers in making clinical decisions about patients, and may be adopted, modified, or rejected according to clinical needs, individual patient considerations, local resources, and physician discretion. A physician must exercise reasonable discretion and have justifiable reasons when there is a decision to not follow a guideline. In every instance, the reasons for not following a guideline must be well documented.

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# OPIOID USE DISORDER (OUD) & THE ROLE OF OPIOID AGONIST THERAPY (OAT) IN SASKATCHEWAN

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The goal of OAT in Saskatchewan is to provide safe, accessible, effective and consistent treatment for individuals with opioid use disorder (OUD).

## Background

### Opioid Use Disorder<sup>1</sup>

Opioid use disorder is best conceptualized as a chronic relapsing illness which, though associated with elevated rates of morbidity and mortality, has the potential to be in sustained long-term remission with appropriate treatment and follow-up.

### Drug Use Trends in Saskatchewan

OUD may involve prescription medications (including pharmaceuticals), or illicitly manufactured opioids, such as heroin or highly potent street fentanyl/fentanyl analogues. While the illicit opioid supply has largely contributed to opioid-related fatalities, pharmaceutical drug diversion continues to be an issue in Saskatchewan and as such, physicians must be prudent in prescribing this class of medication to ensure safe and appropriate use by patients. It is important for prescribers to be aware that a common source of opioids for those who may be drug seeking comes from the medications prescribed to family members. To help limit the diversion of their medications, patients should be educated on to how to securely store, safely use, and properly dispose of opioids that are prescribed to them.

### Canadian Guideline for Opioids for Chronic Non-Cancer Pain

To ensure the optimal prescribing of opioids, physicians should be familiar with the [2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain](#). Patients prescribed high dose opioids should be assessed for appropriateness of an opioid deprescribing plan, opioid minimizing plan and/or conversion to OAT. For some patients, opioids may be causing more harm than good, and reassessment of therapy should be performed regularly, along with thorough patient education. Information on when and how to initiate an opioid taper can be found in the [RxFiles Opioid Taper Newsletter](#).

### Stigma<sup>2, 3, 4</sup>

Stigma refers to the negative attitudes and negative behaviour that marginalizes and disenfranchises people who have substance use, or mental health disorders. Stigma can be manifested in fixed ideas and judgements such as thinking people with substance use or mental health problems are not normal; that they caused their own problems; or that they can simply get over their problems if they wanted to. Negative attitudes and judgements toward others (based on gender, sexual orientation, culture, race, actual, or perceived HIV status) manifest as prejudice and discrimination.

This judgement of others has consequences such as:

- Increased isolation
- People in need of treatment might not seek treatment due to fear of being judged or shunned
- Communities are less accepting of treatment programs
- Patients might feel that they must hide or withhold information (e.g. substance use or HIV status)
- Internalized stigma
- Depression and anxiety escalated by lack of acceptance from family, friends, employers, and the community can lead to relapse

It is critical that prescribers understand stigma, how it is reproduced, and how it can affect others seeking care. Strategies to combat stigma are listed below:

- Know the facts (not the myths)
  - Education specific to substance use, and mental health problems, what brings them on, who is more likely to develop problems, and how to prevent or reduce the severity of problems is necessary for proper care.
- Be aware of attitudes and behaviour
  - Prejudices and judgmental thinking are passed on by society and reinforced by family, friends, and the media. It is important for prescribers to understand how they might be contributing to stigma, or how their own biases might be presenting.
- Use of language
  - The way prescribers speak will influence how others think and speak. Use of accurate and sensitive wording is encouraged. (For example, speak about “a person living with opioid use disorder” (person-centred language) rather than “an addict”)
  - Care environments must understand and reduce stigma by avoiding stigmatizing language such as “addict”, “clean” and “dirty”

To help increase their knowledge and competence regarding stigma, prescribers are encouraged to complete the [Understanding Stigma](#) online course through The Centre for Addiction and Mental Health (CAMH).

### *Trauma-informed care*

Opioid use disorder has been associated with high lifetime prevalence of trauma including physical and sexual abuse, and pregnancy is an especially vulnerable time for individuals. Women are at an increased risk of intimate partner violence during pregnancy, particularly in the case of unintended pregnancies. Care and care environments must be culturally safe and appropriate with trauma awareness.

Useful resource:

**Trauma-Informed Practice & the Opioid Crisis  
A Discussion Guide for Health Care and Social Service Providers**

June 2018

[http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide\\_May-2018.pdf](http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf)

## Treatment Options for OUD

To effectively engage patients in treatment for opioid use disorder, it is important for prescribers to understand the motivational strategies for change. **Appendix A** contains information on *Motivational Strategies for Each Stage of Change*. For individuals with opioid use disorder, some may require treatment, but are not yet ready to engage, or they may have been thinking about treatment but do not know where to begin. Others may be familiar with their treatment options and are ready to act. Each patient is unique and will present with different motivations. Patients should be given the option of engaging in interventions that align with their individual values and beliefs (e.g. based in community, land, and culture).

### Withdrawal Management<sup>5</sup>

For the treatment of OUD, withdrawal management alone (also known as detox or abstinence therapy) is **not recommended** because it is associated with increased risky behaviours such as needle sharing leading to increased morbidity and death. Withdrawal management without linkage to long-term addiction care should be avoided because it is associated with elevated rates of relapse, overdose, and both human immunodeficiency virus (HIV) and Hepatitis C virus (HCV) infections. When discussing treatment options, patients should be informed of the risks associated with withdrawal management and encouraged to consider other treatment options. If a patient chooses withdrawal management over long-term OAT, a slow outpatient taper should be considered.

### Opioid Agonist Therapy Options<sup>6, 7, 8</sup>

The first-line treatment for moderate to severe OUD is OAT, ideally in combination with behavioural and social supports, optimizing the determinants of health and addressing psychosocial factors that influence substance use and quality of life. Currently, there are two medications approved for the treatment of OUD: buprenorphine in combination with naloxone (available as generics and under the trade name Suboxone<sup>®</sup>) and methadone. OAT can stabilize the cycle of intoxication and withdrawal, reduce opioid cravings and block intoxicating effects of other short-acting opioids, including fentanyl. There is significant evidence that OAT reduces the risk associated with behaviours that lead to the transmission of HIV, HCV, and other blood borne pathogens by reducing the sharing of needles and other drug paraphernalia, including spoons, filters, and water. OAT has also been shown to reduce criminal activity associated with drug use and helps support patients to facilitate healthier lifestyles. Opioid use disorder is a chronic relapsing illness that requires a well-functioning care team to address the multifaceted issues of addiction that often require a multidisciplinary approach. Harm reduction measures such as the provision of naloxone kits, outreach services, sterile drug consumption equipment, supervised consumption services, education on harm reduction practices, infectious disease testing, access to primary care, vaccinations, and appropriate referrals to other health/social services (e.g. addiction's counsellors) should be part of a comprehensive harm reduction approach, offered to all patients, in conjunction with pharmacotherapy.

When a patient begins OAT, it is recommended that the patient, prescriber, pharmacist, and addiction counsellor/case manager work collaboratively to assist the patient in reaching their goals of therapy. The table below outlines the roles that each provider plays in the provision of OAT.

In addition to the provision of OAT treatment, specialist in pain, addictions, infectious disease, and mental health may be required for adequate treatment. Every OAT program should encompass harm reduction measures and access to available community programs. A brief overview of OAT and where different services may fit into the treatment plan can be found in **Appendix B**.

<b>HCP Roles in the Provision of OAT<sup>9</sup></b>		
<b>Prescriber</b>	<b>Pharmacist</b>	<b>Addiction Counsellor/ Case Manager</b>
<ul style="list-style-type: none"> <li>• Medical Assessments</li> <li>• Diagnosis</li> <li>• Prescribing medications for opioid agonist therapy</li> <li>• Coordination with pharmacist and counsellor/case manager</li> <li>• Referrals for specialized services</li> <li>• Education</li> </ul>	<ul style="list-style-type: none"> <li>• Dispensing</li> <li>• Regular patient encounters</li> <li>• Observation of witnessed doses</li> <li>• Monitoring for drug interactions</li> <li>• Liaison with prescriber/case manager</li> <li>• Education</li> </ul>	<ul style="list-style-type: none"> <li>• Screening and comprehensive assessment process (including mental health and suicide risk)</li> <li>• Coordinate with pharmacist, prescribers, other case managers (e.g. HIV)</li> <li>• Education</li> <li>• Intervention/Referrals in social and legal matters</li> <li>• Case management, counselling</li> <li>• Evaluation/outcome assessments <i>Sample assessment found in <b>Appendix C</b></i></li> <li>• Referrals to detox for other substances such as stimulants</li> <li>• Referrals to inpatient rehab facilities</li> </ul>

## Understanding the OAT Options

**A prior trial of non-pharmacotherapy or abstinence-based approaches is not a prerequisite for initiating OAT.** Withdrawal management alone is **not recommended** due to poor outcomes.

### *Buprenorphine/Naloxone (Bup/Nx): First-Line Treatment*<sup>10, 11</sup>

Buprenorphine is a long-acting, synthetic opioid used for the treatment of opioid use disorder. Buprenorphine is a partial opioid agonist that can produce sufficient opioid effects to allow patients with OUD to discontinue use without experiencing symptoms of withdrawal. Buprenorphine also has a higher binding affinity and as a result can displace other opioids from the receptors. At moderate doses, the agonist effects of buprenorphine plateau and display a ceiling effect, which makes it safer in overdose situations compared to the effects of full agonist opioids, including methadone (it also results in lower risk of over-sedation). Buprenorphine on its own is very unlikely to cause an overdose, however, combining it with sedatives such as alcohol or benzodiazepines can cause respiratory depression and death.

The naloxone added in the buprenorphine/naloxone product is added to deter injection use. Naloxone has a poor sublingual bioavailability, and as such, the addition of it in the combination product appears to be harmless as it does not interfere with the pharmacokinetics of buprenorphine. Buprenorphine in Canada is only available as a combination product with naloxone, unless for a patient who is pregnant, in which case buprenorphine alone can be available via a [special access program](#).

### Pharmacology of buprenorphine<sup>11</sup>

Feature	Result
Good sublingual/buccal and IV absorption, but poor oral absorption	<ul style="list-style-type: none"> <li>Can be abused intravenously (hence, the addition of the naloxone component)</li> </ul>
Very tight binding (affinity) to opioid receptors	<ul style="list-style-type: none"> <li>Competes with and displaces other opioids from opioid receptors and thus triggers withdrawal in patients who are physically dependent having recently taken opioids</li> <li>Blocks the analgesic action of other opioids</li> </ul>
Slow dissociation from opioid receptors	<ul style="list-style-type: none"> <li>Long duration of action</li> <li>Relieves withdrawal and cravings for 24 hours or more</li> </ul>
Partial agonist with ceiling effect	<ul style="list-style-type: none"> <li>Very low risk of overdose when used on its own</li> <li>May be less effective than higher doses of methadone</li> </ul>
Buprenorphine combined with naloxone	<ul style="list-style-type: none"> <li>When injected, naloxone will trigger withdrawal in patients physically dependent on opioids</li> <li>Acts as deterrent to IV use</li> </ul>

### *Buprenorphine Implant/Depot*

Long-acting preparations of buprenorphine (monthly injections or six-month subdermal implants) may facilitate reintegration into society, reduce personal and health care burdens and enhance medication adherence for patients who are clinically stable.

Currently, there is a lack of long-term safety and effectiveness data; thus, patients must be counselled accordingly.

The subcutaneous injection may be considered once the patient has been stabilized on 8-24mg sublingual bup/nx daily for at least seven days (according to the product monograph). The injection does not require abstinence from other opioids prior to initiation, but this is preferred.

The subdermal implant may be considered once the patient has been stabilized on 8mg (or less) sublingual bup/nx daily (according to the product monograph).

Physicians must only prescribe and/or administer a drug that they have the knowledge, skill and judgment to do so safely and effectively with the appropriate training and competence. Providers are encouraged to refer to individual product monographs to ensure learning requirements are met prior prescribing and administering the formulations.

Physicians are encouraged to collaborate with community pharmacists, prior to prescribing, to ensure that drug coverage is in place.

## Methadone

Methadone is a long-acting, synthetic opioid that has been used in the treatment of opioid use disorder for over fifty years. It is a potent opioid agonist that has good oral bioavailability, a slow onset of action, and a long and variable half-life (average of 24 to 36 hours). It takes four to five days for methadone plasma levels to reach steady state after each dose change. It binds strongly to the mu receptor, rendering the receptor inaccessible to most other opioids. Methadone also binds to other receptors. It prevents withdrawal, decreases cravings, and blocks euphoria produced by short-acting opioids.

Compromised renal function does not preclude the use of methadone and the dosage does not need to be adjusted for patients on dialysis<sup>13</sup>. Because methadone undergoes hepatic metabolism, initiation at lower doses, slower titration and increased monitoring may be required in hepatic impairment.

### Tolerance

- Cross-tolerance between methadone and other opioids is unpredictable.
- Tolerance to the various effects of methadone develops at different rates. Tolerance to the euphoric effects of methadone develops quickly and may be interpreted by patients as being due to an inadequate dose. Tolerance to respiratory depression is less rapid in onset and tolerance to the autonomic side effects is the slowest.
- Tolerance is lost in as little as three days.
- Methadone is potentially lethal, and the risk of toxicity is increased by concomitant ingestion of alcohol and sedative-hypnotics such as benzodiazepines.

### What are the risks and benefits of methadone therapy?

Prescribing methadone requires balance of the risks of adverse effects to the patient and people in the patient's environment with the benefits of treatment (e.g. retention in treatment and a reduction in health harms associated with substance use). As with any opioid, methadone can cause respiratory depression and cardiac arrest. Because of the slow onset of action, the progression of respiratory depression in a person taking methadone is insidious and can go unnoticed by the patient's companions. An added risk factor is methadone's long half-life. Serum methadone level will increase with each successive dose until it reaches steady state (this takes four to five half-lives). During early induction, the new patient is at risk of overdose and death. Taken together, these factors make methadone a medication that must be managed carefully, by clinicians who understand its properties and its dangers. When managed properly, the benefits of methadone maintenance therapy (MMT) far outweigh the risks associated with injection drug use. For patients who have been infected with a bloodborne pathogen, the daily routine for someone with an opioid use disorder often does not lend itself to the degree of treatment compliance necessary to achieve a sustained viral response. Methadone frees the recovering individual from the need to engage in criminal activity to support an expensive drug habit, enabling a greater focus on improved health. Many of the patients entering methadone maintenance have few copings, life, parenting, or employment skills which can all be focused on with a more stable lifestyle. Some patients with opioid use disorder also misuse stimulant; thus, for a significant number of patients, methadone, in and of itself, is not adequate treatment.

Methadone maintenance therapy is a recognized therapy for an OUD. It is not replacing one addiction with another. The term *addiction*, now referred to as a substance use disorder, is a psychiatric and medical diagnosis, the criteria of which are not met by the patient who conscientiously adheres to a medication protocol and treatment plan. In the absence of pharmacological intervention, an individual with an opioid use disorder has roughly a 15% chance of succeeding in recovery. Many patients who discontinue methadone relapse within a year of stopping treatment.

Methadone causes physiological dependence and will result in physical and psychological withdrawal symptoms if discontinued abruptly. This does not constitute "addiction". The treatment of patients with substance use disorders can be complicated by confusion between physiological dependence and addiction. This misunderstanding can result in a reluctance to embark on an appropriate, effective, and compassionate treatment plan.

Each patient must be assessed, treated, and monitored on an individual basis, and MMT must consider the physiologic, psychological, and social aspects of the patient's wellbeing. Successful outcomes through MMT require knowledge, experience, vigilance, and diligence on the part of the physician, the patient and everyone involved in treatment.

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## STANDARDS AND GUIDELINES

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To inquire about the acceptability of educational opportunities, or to submit your certificate of completion for the online course, contact the OATP at CPSS either by phone (306) 244-7355 or via e-mail at [ootp@cps.sk.ca](mailto:ootp@cps.sk.ca)

### 1. Authorization to Prescribe OAT

#### Standards

To prescribe OAT (either Bup/Nx and/or methadone) in Saskatchewan, a physician must:

1. Have a license to practice medicine in Saskatchewan.
2. Have received CPSS Registrar approval (or approval from their designate) to prescribe OAT for the treatment of opioid use disorder. See **Appendix D** for a copy of the form that must be completed and returned to CPSS to request Registrar approval. This form is also available on the [cps.sk.ca](http://cps.sk.ca) website.

*Note: an exception applies to Hospital-Based Temporary Prescribers (Section 3) and Corrections-Based Temporary Prescribers (Section 4).*

3. Meet the educational requirements outlined in the *CPSS OAT Standards & Guidelines* (see Section 2 entitled: Educational Requirements for the Prescribing of OAT).
4. Have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom prescribes OAT.
5. Agree to participate in an audit in prescribing of Bup/Nx or methadone if requested by the CPSS Registrar.
6. Agree to an interview with the CPSS Registrar or their designate, if requested.
7. Have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients who are prescribed OAT.
8. Plan for after-hour care of their patients prescribed OAT if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OAT Standards & Guidelines*.

*Note: this does not mean that a prescriber must be available for their patients 24/7/365. Patients must have access to continuity of care. See the CPSS [Medical Practice Coverage](#) Policy for detailed information.*

9. Ensure any patient on OAT under their care receives continued care from another physician trained in OAT according to standards described in the *CPSS OAT Standards & Guidelines* when they are going to be away or are suspending their practice.
10. Have access to counselling and pharmacy services.  
*Note: this standard means that prescribers are aware of the available services in their area, and that the prescriber knows how to access these services or refer patients to the services available.*
11. Make efforts to provide non-pharmacological support to their patients (e.g., addiction services, counselling, harm reduction, community programs, etc.).

## 2. Educational Requirements for the Prescribing of OAT for the Treatment of OUD

### *Buprenorphine/Naloxone (Bup/Nx) Initiating Prescribers*

*Due to the requirements of care when prescribing buprenorphine/naloxone (vs methadone), the only distinction between an Initiating and a Maintaining Prescribers for Bup/Nx, is that the Initiating Bup/Nx Prescriber evaluates patients on their suitability for treatment with OAT and may initiate patients on Bup/Nx while working closely with an interdisciplinary team that offers a range of services and support to the patient.*

*To inquire about the acceptability of educational opportunities, or to submit your certificate of completion for the online course, contact the OATP at CPSS either by phone (306) 244-7355 or via e-mail at [oatp@cps.sk.ca](mailto:oatp@cps.sk.ca)*

### Standards

1. Bup/Nx Initiating Prescribers must have completed an educational program on prescribing of buprenorphine approved by the CPSS Registrar.

This includes:

- The online education module by Schering-Plough Canada available at: [www.suboxonecme.ca](http://www.suboxonecme.ca) ; **OR**
  - The Centre for Addiction and Mental Health (CAMH) Buprenorphine Naloxone Treatment for Opioid Use Disorder course available at: <https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/buprenorphine-naloxone-treatment-for-opioid-use-disorder>; **OR**
  - The UBC CPD Provincial Opioid Addiction Treatment Support Program Online Course <https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program>
2. The Bup/Nx Initiating Prescriber has spent a minimum of one day, or equivalence as authorized by the CPSS (e.g. CPSS approved case-based learning), with another physician who has received approval from the CPSS Registrar to allow that physician to prescribe OAT, who has met the requirements of the CPSS bylaw 19.1 to prescribe Bup/Nx, and who prescribes Bup/Nx as part of their regular practice.

### Guidelines

1. Bup/Nx Prescribers are encouraged to pursue a minimum of 20 hours of formal continuing medical education in some aspect of addiction medicine every 5 years.
2. Prescribers are encouraged to complete the [Understanding Stigma](#) online course through CAMH.

## *Buprenorphine/Naloxone (Bup/Nx) Maintaining Prescribers*

*This section applies to physicians who provide Bup/Nx for OUD to patients who have been evaluated by a Bup/Nx Initiating Prescriber and deemed appropriate for Bup/Nx, or who have been stabilized by another prescriber on Bup/Nx and transferred to the Bup/Nx Maintaining Prescriber.*

1. Bup/Nx Maintaining Prescribers must have an ongoing association with an experienced Initiating Prescriber who serves as a resource to the Maintaining Prescriber.
2. Bup/Nx Maintaining Prescribers shall understand Bup/Nx pharmacology and the completion of an OAT workshop/course recognized by the CPSS is strongly recommended.

*To inquire about the acceptability of educational opportunities, contact the OATP at CPSS either by phone (306) 244-7355 or via e-mail at [oatp@cps.sk.ca](mailto:oatp@cps.sk.ca)*

### Guidelines

1. Bup/Nx Maintaining Prescribers are encouraged to pursue a minimum of 20 hours of formal continuing medical education in some aspect of addiction medicine every 5 years (time spent at a recognized OAT workshop/course qualifies).
2. Prescribers are encouraged to complete the [Understanding Stigma](#) online course through CAMH.

## Methadone Initiating Prescribers

*This section applies to physicians who prescribe methadone for opioid use disorder in a private or in a Health Authority supported OAT clinic. These prescribers evaluate patients on their suitability for treatment with OAT and initiate patients on methadone, working closely with an interdisciplinary team that offers a range of services and support to the patient.*

### Standards

1. Methadone Initiating Prescribers will have the following training and experience:

a) Completion of a methadone workshop/course recognized by the CPSS;

*Contact CPSS to request approval for a workshop or course, or for a list of approved events at 306-244-7355 or [oatp@cps.sk.ca](mailto:oatp@cps.sk.ca);*

b) A period of direct training (for two days or until determined competent by the CPSS-approved Initiating Prescriber) or equivalence of direct training as authorized by the CPSS (e.g. CPSS approved case-based learning), supervision and mentorship with an experienced, CPSS-approved Initiating Prescriber;

*Access the Saskatchewan Health Information Resources Program (SHIRP) or contact the CPSS for a list of approved prescribers at 306-244-7355 or [oatp@cps.sk.ca](mailto:oatp@cps.sk.ca);*

c) Documentation of clinical competence from a mentoring prescriber (See **Appendix E** for a template for mentors to complete when supervising a potential OAT prescriber);

d) CPSS approved mentorship and support from an established methadone prescriber, during the first two years of practice.

2. Methadone Initiating Prescribers will pursue ongoing education relevant to OAT. Physicians must provide documentation of OAT-related education that is acceptable to the CPSS.

*To obtain a list of Initiating Prescribers, access SHIRP and to inquire about the acceptability of educational opportunities, contact the OATP at CPSS either by phone (306) 244-7355 or via e-mail at [oatp@cps.sk.ca](mailto:oatp@cps.sk.ca)*

Examples of education acceptable to the CPSS are:

- a) Completion of a recognized course on the fundamentals of addiction medicine within two years of receiving approval from the CPSS Registrar to prescribe methadone for OUD;
  - b) A minimum of 30 hours of formal continuing medical education in addiction medicine every five years;
  - c) Education equivalent acceptable to the Registrar of the CPSS.
3. New methadone prescribers will be limited to a maximum of 25 patients until their first audit. The prescriber should notify the CPSS when 25 patients have engaged in OAT under their care for further guidance.

## *Methadone Maintaining Prescribers*

*This section applies to physicians who provide methadone for OUD to a limited number of stabilized patients as a part of their practice.*

1. Methadone Maintaining Prescribers must have an ongoing association with an experienced Initiating Prescriber who serves as a resource to the Maintaining Prescriber.
2. Methadone Maintaining Prescribers shall understand methadone pharmacology and complete an OAT workshop/course recognized by the CPSS.

### Guidelines

1. Methadone Maintaining Prescribers are encouraged to pursue a minimum of 20 hours of formal continuing medical education in some aspect of addiction medicine every five years (time spent at a recognized OAT workshop/course qualifies).
2. Prescribers are encouraged to complete the [Understanding Stigma](#) online course through CAMH.

### 3. Hospital-Based Temporary Prescribers (HBTPs)

*This section applies to physicians who do not prescribe OAT as a part of their practice but may, for a brief period, prescribe Bup/Nx or methadone for the treatment of opioid use disorder to a patient in hospital. If a physician is not a patient's current OAT prescriber, the prescriber is considered a Temporary Prescriber. Whatever the situation, these physicians may not have specialized knowledge of opioid use disorder but are responsible for patients who actively receive OAT. Unless there is a contraindication, OAT should always be maintained during hospital admission to prevent loss of tolerance and unnecessary withdrawal. Patients must receive care in a non-judgemental environment that supports safety and treatment adherence, and that recognizes that some patients may continue to use substances while hospitalized.*

#### Standards

1. A HBTP must have a license to practice medicine in Saskatchewan.
2. HBTPs are permitted to prescribe Bup/Nx or methadone to patients in a hospital setting without obtaining the approval of the CPSS Registrar if the following terms and conditions are met:
  - a) For inpatients: the patient must currently be receiving Bup/Nx or methadone treatment prior to their hospitalization (or admission to an equivalent acute care facility in rural centres).

For patients seen in the Emergency Room: Subject to paragraph 7 below, the patient must currently be receiving Bup/Nx or methadone treatment prior to being treated in the Emergency Room;

- b) the HBTP must:
  - i. Be working in a hospital setting (or equivalent acute care facility in rural centres);
  - ii. Only prescribe the continuation of Bup/Nx or methadone as initiated by a prescriber currently approved to prescribe OAT to a patient while that patient is under their professional treatment in an acute care facility;
  - iii. Confirm the daily dose, date/time of last administration, whether the patient has been receiving take-home doses and the last dispense date of take-home doses from a reliable source (e.g. from the patient if appropriate and preferably, the dispensing pharmacy. Caution must be applied with reviewing PIP for dosing information related to methadone compounds);

- iv. *\*Only for patients receiving methadone\** Consult the community-based prescriber prior to re-initiating therapy if the last methadone dose was not taken/administered within the previous 48 hours. An exception to this may be made only in an urgent or emergent situation (e.g. when the patient is admitted for an acute or emergent operative indication, or the patient is admitted to the ICU). Be aware that when methadone doses are held, patients can lose their tolerance to the effects of the medication and are at an increased risk of overdose upon re-initiation of the methadone;
  - v. *\*Only for patients receiving methadone\** Not adjust the dose without first consulting the community-based prescriber (Initiating or Maintaining Prescriber). This includes increasing, decreasing, or splitting of the daily dose. If medically necessary, the dose may be held – if the dose is held for more than 24 hours, the community-based prescriber must be consulted prior to re-initiating therapy. An exception to this may be made only in an urgent or emergent situation (e.g. when the patient is admitted for an acute or emergent operative indication, or the patient is admitted to the ICU) in which case the dose may be decreased, if necessary, but never increased. Be aware that when methadone doses are held, patients can lose their tolerance to the effects of the medication and are at an increased risk of overdose upon re-initiation of the methadone;
  - vi. *\*Only for patients receiving methadone\** Order an ECG if clinically indicated (e.g. the patient is on more than 120mg of methadone or has risk factors for prolonged QTc);
  - vii. Only prescribe Bup/Nx or methadone for the management of opioid use disorder;
  - viii. Ensure that the community-based prescriber is informed of the patient's hospitalization (or admission to an equivalent acute care facility in rural centres) **OR** visit to the Emergency Room and coordinate the issuance of Bup/Nx or methadone prescriptions when the patient leaves the hospital (or equivalent acute care facility in rural centres) or the Emergency Room.
3. Prescribing of OAT is only for the duration of the patient's hospital admission. An exception to this may be made only when a patient is discharged from the facility on a weekend. The physician is then permitted to prescribe OAT for a maximum duration of 72 hours after discharge and the community-based prescriber (Initiating or Maintaining

Prescriber) must be notified at discharge that OAT was prescribed to avoid double dosing.

4. Prescribing carried doses is not permitted (i.e. all doses provided must be witnessed), except in consultation with the community-based prescriber.
5. HBTPs must collaborate with the community-based prescriber (or the individual who may be covering the community-based prescriber's patients) and any other treating prescribers for all changes to the OAT dosage, frequency, or addition of medications that have the potential to interact with the OAT medication (see **Appendix F** for a list of interacting medications).
6. Prior to the patient's discharge from hospital or the Emergency Room, the HBTP must collaborate with the community-based prescriber and dispensing community pharmacy on:
  - a. Discharge plans
  - b. Any changes in dosage
  - c. The prescribing of short-term opioid analgesics, psychoactive medications, or medications with the potential for interaction with OAT

Early coordination is important, especially if discharge is premature or unexpected and/or the patient resides in a remote location which requires prescribing coordination.

7. Nothing in this section applies to a prescriber who provides Bup/Nx treatment in an Emergency Department following a protocol established by the Saskatchewan Health Authority or the hospital in which it is prescribed.

## Guidelines

1. HBTPs should be familiar with the basics of OAT, as obtained through previous education such as an introductory workshop/course, or mentorship by a prescriber with experience in the provision of OAT.
2. Any physician who manages patients on OAT on a routine basis is expected to apply for approval from the CPSS Registrar to prescribe OAT for the treatment of opioid use disorder.

## 4. Corrections-Based Temporary Prescribers (CBTPs)

*This section applies to physicians who do not prescribe OAT as a part of their practice but may, for a brief period, prescribe Bup/Nx or methadone for the treatment of opioid use disorder to a patient in a correctional facility. If a physician is not a patient's current OAT prescriber, the prescriber is considered a Temporary Prescriber. Whatever the situation, these physicians may not have specialized knowledge of opioid use disorder but are responsible for patients who actively receive OAT. Unless there is a contraindication, OAT should always be maintained during incarceration to prevent loss of tolerance and unnecessary withdrawal. Care standards in correctional settings must meet those of treatment standards in the community.*

### Standards

1. CBTPs must have a license to practice medicine in Saskatchewan.
2. CBTPs are permitted to prescribe Bup/Nx or methadone to patients in a correctional facility without obtaining the approval of the CPSS Registrar if the following terms and conditions are met:
  - a) the patient must currently be receiving Bup/Nx or methadone treatment prior to their incarceration.
  - b) the CBTP must:
    - i. Be working in a correctional facility setting (or equivalent centres);
    - ii. Only prescribe the continuation of Bup/Nx or methadone as initiated by a prescriber currently approved to prescribe OAT to a patient while that patient is under their professional treatment in a correctional facility;
    - iii. Confirm the daily dose, date/time of last administration and whether the patient has been receiving take-home doses and the last dispense date of take-home doses from a reliable source (e.g. from the patient if appropriate and preferably, the dispensing pharmacy. Caution must be applied with reviewing PIP for dosing information related to methadone compounds);
    - iv. *\*Only for patients receiving methadone\** Consult the community-based prescriber prior to re-initiating therapy if the last methadone dose was not taken/administered within the previous 48 hours. An exception to this may be made only in an urgent or emergent situation. Be aware that when methadone doses are held or missed, patients can lose their tolerance to the effects of the medication and are at an increased risk of overdose upon re-initiation of the methadone;

- v. *\*Only for patients receiving methadone\** Not adjust the dose without first consulting the community-based prescriber (Initiating or Maintaining Prescriber). This includes increasing, decreasing, or splitting of the daily dose. If medically necessary, the dose may be held – if the dose is held for more than 24 hours, the community-based prescriber must be consulted prior to re-initiating therapy. An exception to this may be made only in an urgent or emergent situation. Be aware that when methadone doses are held or missed, patients can lose their tolerance to the effects of the medication and are at an increased risk of overdose upon re-initiation of the methadone;
  - vi. *\*Only for patients receiving methadone\** Order an ECG if clinically indicated (e.g. the patient is on more than 120mg of methadone or has risk factors for prolonged QTc);
  - vii. Only prescribe Bup/Nx or methadone for the management of opioid use disorder;
3. Prescribing of OAT is only for the duration of the patient's incarceration. However, upon release from a correctional facility, the CBTP must ensure continuity of care for the patient on OAT and provide an appropriate OAT prescription to prevent an interruption of therapy (i.e. must provide a prescription of duration sufficient to last the patient until they can contact their regular OAT clinic during regular business hours OR until the patient can attend their appointment with the community-based prescriber).
  4. Prescribing carried doses is not permitted, except in consultation with the community-based prescriber.
  5. CBTPs must collaborate with the community-based prescriber and any other treating prescribers for all changes to the OAT dosage, frequency, or addition of medications that have the potential to interact with the OAT medication (see **Appendix F** for a list of interacting medications).
  6. CBTPs must make every attempt to educate the patient about the potential for relapse and the dangers of overdose, particularly in the lead-up to release. The patient should receive a take-home naloxone kit and overdose prevention training prior to release.
  7. Prior to the patient's release from a correctional facility, the CBTP must collaborate with the community-based prescriber on:
    - a) Discharge plans
    - b) Any changes in dosage
    - c) The prescribing of short-term opioid analgesics, psychoactive medications, or medications with the potential for interaction with OAT

Early coordination is important, especially if release is premature or unexpected and/or the patient resides in a remote location that requires prescribing coordination. Information regarding

medications prescribed and dispensed during federal incarceration do not appear on the PIP and communication between the CBTP and community provider is particularly important.

## Guidelines

1. Work with the patient to avoid discontinuing OAT simply because of non-reassuring UDS results.
2. CBTPs should be familiar with the basics of OAT, as obtained through previous education such as an introductory workshop/course, or mentorship by a prescriber with experience in the provision of OAT.
3. Any Prescriber who manages patients on OAT on a routine basis is expected to apply for approval from the CPSS Registrar to prescribe OAT for the treatment of opioid use disorder.

## 5. Patient Assessment for Admission to an OAT Program (OATP)

*This section details the steps prescribers must complete before starting a patient on OAT. Those who qualify for admission into an OATP are patients who meet the criteria of Opioid Use Disorder (see **Appendix G** for the DSM-5 criteria). The patient must be assessed to determine their suitability for OAT, have their history documented, have appropriate investigations completed, and have informed consent obtained. The patient must be made aware of treatment options and if it is decided that the patient will benefit from OAT, an agreement between the patient and the prescriber is made, and a detailed treatment plan is developed.*

*Note that there are circumstances in which patients should receive priority admission into treatment programs. Due to relevant risk to the individual, society, and public health certain patients should receive consideration for immediate entry into OATP. These may include pregnant women and individuals at high risk for contracting or transmitting blood borne viruses (e.g. HIV, HCV).*

The goals of Opioid Agonist Treatment Programs (OATPs) are to: <sup>12, 13</sup>

- I. Change the pattern of drug use to bring substance use into remission.
- II. Achieve highest possible level of psycho-social function.
- III. Assess for and treat:
  - complications and psychiatric comorbidities;
  - withdrawal symptoms; and
  - intoxication/overdose.
- IV. Facilitate integrated pharmacologic and non-pharmacologic treatment for OUD.
- V. Prevent relapse.
- VI. Prevent harm via:
  - safer opioid prescribing;
  - provision and distribution of naloxone kits;
  - needle exchange programs; and
  - safe sex information.
- VII. Promote use of community-based programs, addictions programs, and get patients access to vocational, recreational, and education to promote a healthier lifestyle

## Standards<sup>14</sup>

Assessment of patients with opioid use disorder must include the following (i.e. should be documented on the patient medical record) \* *Sample Assessment form & Clinical note can be found in **Appendix H**\**:

1. Complete a comprehensive assessment, including:
  - Appropriate physical examination [with special attention to signs of opioid withdrawal, needle tracks, abscesses, malnutrition, jaundice, and hepatosplenomegaly (or other stigmata of liver disease)]
  - Medical history (cardiovascular health, details about chronic or recurrent pain)
  - Psychiatric history
  - Mental health (including suicidal ideation)
  - Substance-use history (including alcohol and tobacco) and the pattern of drug use
  - Presence of any substance use disorders
  - Process addictions diagnoses (e.g., gambling)  
*\*for more information see **Appendix J**\**
  - Addiction treatment history
  - Assessment for domestic violence
2. Family history including history of substance use, addiction treatment history, and response.
3. Biopsychosocial assessment with relevant information regarding the patient's current and past social situation, including supports (e.g. family, clergy, friends), stressors (e.g. legal, employment, financial, children at risk, partner's drug use and housing) and high-risk behaviours (e.g. needle sharing, involvement in sex trade).
4. An initial Urine Drug Screening (UDS) must be obtained prior to initiation of OAT. If unable to obtain prior to OAT initiation, thoroughly document rationale and plans for monitoring. In such cases where a UDS is not obtained prior to initiation, to prevent potential overdose (especially in patients who may actually be opioid-naïve), treatment with Bup/Nx (vs. methadone) is strongly advised.

[Problematic Alcohol Use](#) is the most common concurrent substance use issue. It is critical that all patients be screened for problem drinking at initiation and intermittently. Patients taking OAT who engage in problem drinking demonstrate poor outcomes and experience higher morbidity and mortality rates than those who do not. Patients should be advised to abstain from alcohol.

5. Laboratory assessment which includes the following:
  - CBC
  - Liver and kidney function panels
  - HIV and Hepatitis A, B and C serology
  - Syphilis, chlamydia, and gonorrhoea serology
  - TB testing, when appropriate
  - Pregnancy test for all women of child-bearing age
  - ECG if indicated (e.g. for patients who will be initiated on methadone)
6. Documented communication with the patient's prior OAT prescriber, family physician, or other primary health care providers who have prescribed to the patient in the three months prior, that the patient is being initiated on OAT.
7. Documented review of the patient's prescribing profile (e.g., PIR or eHR), including consideration of drug interactions with current medication regimen, especially medications that prolong QTc interval (for patients who may be receiving methadone) or cause sedation/respiratory depression (see **Appendix F**).
8. Documented treatment goals and plans, with a signed treatment agreement (See **Appendix K** for an example of a treatment agreement). A copy must be given to the patient and to the dispensing pharmacy (treatment agreement can be faxed to the dispensing pharmacy along with the initial OAT prescription).

*Treatment goals are objective outcomes that the patient and prescriber expect will result from Bup/Nx or methadone maintenance treatment. These goals may or may not involve abstinence from substance use and they may extend beyond substance use outcomes. Treatment plans describe the steps required to achieve the goals. Once a goal has been defined, a brief outline of the plan for achieving that goal should be documented to help direct patient care. The following table represents examples of treatment plans and goals.*

Examples of Treatment Goals vs Plans	
Goal	Plan
<p><b>Stop illicit substance use</b></p> <p>Barriers are unsafe housing, drug-dealing partner, and lack of non-chemical coping skills (recognizing some patients may never reach total abstinence from illicit opioids, documented reduction is also a reasonable goal).</p>	<ul style="list-style-type: none"> <li>Review patient weekly and adjust the Bup/Nx or methadone dose as necessary</li> <li>Refer patient to psychosocial supports such as safe housing and access to a women's shelter</li> <li>Monthly treatment team meeting to review progress</li> <li>Document reduction in illicit opioid use</li> </ul>
<p><b>Address health concerns</b></p> <p>Patient is HIV positive, has multiple skin infections and recurrent cellulitis, as well as untreated mental illness.</p>	<ul style="list-style-type: none"> <li>HIV work-up and consider referral to immunodeficiency specialist</li> <li>Contact community outreach nurse re: daily change of dressings and antibiotic administration</li> <li>Refer to community mental health service with referral letter</li> </ul>

9. The patient must understand the rights, responsibilities, risks, and the daily requirements of OAT treatment.
10. The prescriber must encourage the patient to include non-pharmacological measures (e.g. addiction counselling) as a part of their treatment plan.
11. The patient must be informed and understand the impact of OAT on their health and activities, and all the significant risks of treatment, particularly during initiation and with any increase in dosage.
12. *\*For patients receiving methadone treatment only\** Prescribers must inform patients of arrhythmia risk when they prescribe methadone. Additionally, all patients should have an ECG on initiation, and must have an ECG for doses greater than 120 mg/day. Lack of access to ECGs should not be a barrier to receiving OAT. If ECGs are not readily available, prescribers must use clinical judgment to guide decisions about initiating OAT.
13. A comprehensive harm reduction approach including the following should be offered to all patients regularly:
  - Outreach services
  - Access to naloxone
  - Sterile drug consumption equipment
  - Supervised consumption services
  - Education on harm reduction practices
  - Infectious disease testing
  - Access to primary care
  - Access to vaccinations
  - Appropriate referrals to other health and social services

14. Psychosocial treatment, based on individual needs, should be considered alongside all pharmacological treatments for OUD but a patient's decision to decline psychosocial treatment or the absence of available treatment should **not** preclude or delay pharmacological treatment of OUD. Psychosocial treatment options may include<sup>15</sup> :

- Individual/group counselling
- Linkages to existing support systems
- Referrals to community-based services
- Recovery support services
- Case management
- Social needs assistance (e.g. employment, housing, legal services)

## 6. OAT Prescriptions

*The safe dispensing of Bup/Nx and/or methadone begins with a well-written prescription. Collaboration and communication between prescribers and pharmacists enhance patient safety. This section outlines what must be present in any prescription for OAT.*

### Standards

1. Prescribers must avoid financial conflicts of interest when choosing medications, pharmacies, and dispensing schedules.
2. OAT prescriptions must be written on the prescriber's personalized prescription pad **OR** generated through an electronic medication record (EMR) program (e.g., Accuro, MedAccess), unless dispensed from a hospital pharmacy for in-patient use.
3. All OAT prescriptions must be faxed or sent electronically to the pharmacy (i.e., they should never be handed to patient to take to the pharmacy). A physician may provide a verbal prescription if the physician concludes that it is not reasonably possible to provide an electronic prescription. The physician must include the requirements outlined in Regulatory Bylaw 18.1(c).
4. Prescriptions must specify all the following:
  - a) Start and end dates;
  - b) Days of the week to be supervised by daily witnessed ingestion (DWI);
  - c) Carried doses (with the number and days of week that are to be given as take-home doses specified);
  - d) OAT dose written in numbers and total daily milligrams (e.g., methadone 50mg once daily witness ingestion);
  - e) Any special instructions and extraordinary situations (e.g. instructions for any formulation changes of methadone compounds such as using flavourings such as grape flavoured tang or Crystal Light instead of orange flavoured tang; instructions on dispensing of other medications concurrent to OAT such antiretrovirals).
5. *\*For patients receiving methadone treatment only\** Methadone must be dispensed in crystalline suspension or in a form that reduces its diversion or potential for abuse. The tablet formulation (Metadol® most commonly available) should not be prescribed for OUD as it can be easily diverted. If a patient requests methadone in a form that can be more easily diverted or misused (i.e., the tablet formulation), the Maintaining Prescriber must consult with the Initiating Prescriber. Only an Initiating Prescriber can change a prescription to a non-crystalline suspension and must document the reason for doing so.

6. Prescribers must communicate with the patient's pharmacist on the management of spoiled, lost and missed doses, either with each prescription or as general instructions for all OAT prescriptions. For more information on spoiled, lost and missed doses see Section 9.
7. With any change in total daily dosage, the prescriber must:
  - a) Cancel the existing prescription; and
  - b) Issue a new prescription based on the Standards cited above.

## Guidelines

To improve a patient's adherence to treatment, the duration of an OAT prescription should not exceed the interval between clinical visits. See Appendix L *Sample Dispensing Schedule*.

## 7. Initiation of OAT

Opioid agonist therapy with Bup/Nx is the preferred first-line treatment due to its reduced risk of overdose. Bup/Nx also facilitates safer take-home dosing, as well as less frequent medical appointments.<sup>16</sup> Below is a resource comparing OAT options, and although Bup/Nx is considered first-line, there may be circumstances in which methadone is the preferred and more appropriate treatment.

Situations where <b>buprenorphine/naloxone</b> may be preferred <sup>17</sup>	Situations where <b>methadone</b> may be preferred <sup>18</sup>
When methadone is contraindicated, such as for patients with: <ul style="list-style-type: none"> <li>- Presence of, History of, or increased risk of Prolonged QT interval</li> <li>- History of methadone allergy</li> </ul>	Situations where opioid withdrawal during induction is hazardous (e.g. CV instability, pregnancy)
History of significant side effects of methadone such as: <ul style="list-style-type: none"> <li>- Sexual side effects on methadone (amenorrhea, reduced libido)</li> <li>- Severe sedation or constipation with methadone</li> </ul>	Prior inability to stabilize on buprenorphine/naloxone treatment
Increased risk of toxicity from a full mu agonist (such as methadone): <ul style="list-style-type: none"> <li>- If a lower tolerance to opioids is suspected (Assess degree of tolerance. Consider amount, pattern, and route of opioid use).</li> <li>- Concurrent heavy or unstable use of sedating drugs, medications (e.g., benzodiazepines, alcohol)</li> <li>- If elderly<sup>19</sup> (&gt;60)</li> <li>- If significant respiratory illness (e.g. severe bronchial asthma, chronic obstructive airway)</li> </ul>	History of misusing buprenorphine/naloxone via injection
Good prognostic factors such as: <ul style="list-style-type: none"> <li>- Brief history (&lt;1 year) of opioid misuse</li> <li>- Strong social supports</li> <li>- Adolescents and young adults</li> </ul>	Patient side effects with or allergy to buprenorphine/naloxone or its excipients such as acesulfame
History of successful stabilization with buprenorphine/naloxone	Severe dry mouth that affects the sublingual dissolution of the tablet (e.g. due to chemotherapy, Sjogren's syndrome) – consider prescribing the film formulation
Patient choice and access, regarding geographic areas where methadone is not available in timely manner or when challenging pharmacy access makes alternate day dosing of buprenorphine/naloxone desirable	History of stabilization with methadone
	Patient choice

Buprenorphine/Naloxone Advantages <sup>20</sup>	Methadone Advantages <sup>21</sup>
Lower risk of public safety harms if diverted	Potentially better treatment retention, especially with patients with higher intensity opioid use disorder (e.g. long history of opioid use, injection heroin use, high tolerance, and frequent use) or at risk of dropping out
Milder adverse effects profile and lower risk of overdose	
Easier to transition from buprenorphine/naloxone to methadone if treatment is unsuccessful <sup>22</sup>	May be more effective for withdrawal symptom control in chronic severe OUD
Shorter time to reach therapeutic dose (one to three days)	Treatment initiation may be easier, because patients do not need to be in withdrawal before beginning treatment, which may not be tolerable.
Lower risk of toxicity and drug-drug interactions	
Milder withdrawal symptoms when discontinuing treatment	
Optimal for rural and remote locations	
More flexible dosing schedule possible (e.g. alternate day dosing, less than daily dosing, earlier provision of one to two week take-home prescription)	
Easier to adjust and re-titrate following missed dose due to partial agonist properties	
Optional transition to long-acting preparations (monthly injections or subdermal implants)	

Buprenorphine/Naloxone Disadvantages	Methadone Disadvantages
Lower treatment retention, particularly in higher intensity patient with OUD with low dose buprenorphine/naloxone.	Higher risk of overdose, leading to respiratory depression and/or QT prolongation.
May cause precipitated withdrawal.	More severe adverse effects profile (e.g., somnolence, erectile dysfunction, cognitive blunting).
Suppression of withdrawal may be inadequate for individuals with high opioid tolerance.	Longer time to reach therapeutic dose.
Reversing the effects of overdose can be challenging due to pharmacology of buprenorphine (high affinity for opioid receptors).	Challenging to transition from methadone to buprenorphine/naloxone if unsuccessful treatment, in part because patient must be in withdrawal to initiate buprenorphine/naloxone.
Patients require education on how to take sublingual doses correctly.	Higher public safety harms if diverted, due to misuse.
Nonadherence to treatment may require frequent re-inductions.	Higher potential for drug-drug interactions, especially regarding other medications that may prolong QT interval, for example SSRIs like citalopram (See <b>Appendix F</b> for a list of interacting medications).
	QT prolongation and increased risk of arrhythmia.
	More expensive if prescribed as daily witnessed doses (for those patients without drug coverage).
	Witness dosing and schedule is an increased burden. However, it may provide needed consistency and structure. Issues regarding adequate transportation or access to daily dosing should be kept in mind.

## Initiation with Buprenorphine/Naloxone

Before a patient can begin their initial dose of Bup/Nx they must be in opioid withdrawal of moderate intensity. A score equal to or greater than 13 on the Clinical Opiate Withdrawal Scale (COWS) may be a useful reference.<sup>23</sup> If Bup/Nx is given prior to moderate or severe withdrawal it will lead to therapy-induced precipitated withdrawal (more info on precipitated withdrawal is provided in this section). The time required for a patient to achieve a withdrawal differs from patient to patient and is dependent upon the drug(s) of abuse. For example, the withdrawal of illicit drugs can be difficult to predict because they may be contaminated with other opioids or excipients used to stretch supply and increase potency of illicit drugs or may metabolize differently compared to pharmaceutical grade medications. For these reasons it is important to assess symptoms and physical manifestation of withdrawal. To assess level of opioid withdrawal a health care provider can use any of the following:

- Clinical Opioid Withdrawal Score ([COWS](#))
  - A score of 13 or more equates to moderate withdrawal
- Subjective Opioid Withdrawal Scale ([SOWS](#))
  - A score of 11 or more equates to moderate withdrawal
- Objective Opioid Withdrawal Scale ([OOWS](#))

If sufficient withdrawal (i.e. moderate to severe) has been assessed, then induction may begin.

Below is an excerpt from: British Columbia Ministry of Health. (2018). *Opioid Use Disorder: Diagnosis and Management in Primary Care*. (p. 7 & 8) Retrieved from <https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/opioid-use-disorder.pdf>

*There is emerging research regarding the safety of unobserved or home-based induction. For such a treatment strategy a physician must be experienced and comfortable with buprenorphine/naloxone induction. Use of an induction strategy that is flexible should be limited, but some patients may benefit. Individuals may require every induction dose to be witnessed by the prescriber or pharmacist. Others may benefit from having the first dose unobserved and then checking in at the office later on Day 1, while others may be comfortable with self-managing all of Day 1, followed by an office visit on Day 2. Others may have initial doses witnessed and then transfer to unobserved home dosing. A combination of these pathways may be created to suit patient, caregiver, and practitioner preferences.*

*Patients may qualify for home induction if:*

- *They can safely store medication*
- *They have a reliable caregiver at home who can monitor and help if needed*
- *They have previous experience with buprenorphine/naloxone*
- *There are barriers to office attendance*

*For home induction it is expected that practitioners provide:*

- *Contact information including out of hours advice if needed*
- *Written instructions for home induction dosing and timing that is reviewed by the patient and caregiver in advance*
- *Regular scheduled follow-up by phone or in office*

Once the patient arrives to the clinic/pharmacy in a state of withdrawal, the first dose of buprenorphine/ naloxone (2 to 4mg) may be given. This visit should be planned to be earlier in the day because after the first dose is given the patient should be re-assessed periodically throughout the day. It may be easier for the patient to achieve withdrawal and abstain from opioids for the required 6 to 12 hours over-night, preferred scheduling of the first induction dose in this case would be in the morning. Once the drug is administered sublingually it will take several minutes under the tongue for it to dissolve completely. This can be an issue for patients with OUD as dry mouth is a common side effect of opioid use. Approximately one hour after the initial induction dose (2 to 4mg) of buprenorphine/naloxone a prescriber should be assessing for precipitated withdrawal, which presents as significantly worse than anticipated withdrawal symptoms.

## Precipitated Withdrawal

Precipitated withdrawal is a rapid and intense onset of withdrawal symptoms. It can occur if the patient is given a dose of Bup/Nx when he/she is not at an adequate level of withdrawal (i.e. moderate to severe unless using a microdosing induction).<sup>24</sup> This occurs because the high affinity buprenorphine will displace the other opioid of abuse from the mu-receptor causing a rapid decrease in receptor activity and the precipitation of withdrawal symptoms.<sup>25</sup> If this occurs, the prescriber should explain what has occurred, explain that the symptoms should subside in less than 12 hours, and consider non-opioid symptomatic treatment. Precipitated withdrawal is not life-threatening and does not generally require emergency department visits. It is important to offer support and encourage the patient to continue induction because experiencing a precipitated withdrawal may discourage patients from further attempts to seek out addiction's treatment.<sup>26</sup>

If the decision is made to **continue** induction despite the precipitated withdrawal, 2mg of Bup/Nx can be administered every 1 to 2 hours until withdrawal symptoms subside (with a maximum of 12mg/3mg on the first day).<sup>27</sup>

If the decision is made to **stop** induction, additional doses of Bup/Nx should not be given as it will worsen precipitated withdrawal. The patient should then present for another trial of induction at a future date.

In either event of a precipitated withdrawal (continued or stopped induction) non-opioid symptomatic treatment for withdrawal may be offered (clonidine, oral anti-emetics, anti-diarrheal, NSAIDs, or acetaminophen). See **Appendix M Opioid Withdrawal and Tolerance** for more information.

A few hours after the first dose of buprenorphine/naloxone have been administered, if precipitated withdrawal has not occurred, the patient can be reassessed for the effectiveness of treatment. When withdrawal symptoms are relieved, induction Day 1 is complete. If withdrawal symptoms are severe, or have abated and returned, then an additional dose of 2 to 4mg of Bup/Nx can be given.

	Day 1	Day 2	Day 3 & onward
<b>Maximum Dose</b> (Buprenorphine/Naloxone)	12mg/3mg	16mg/4mg	24mg/6mg

Patients should be reassessed within three days of the first dose. If withdrawal symptoms continue to be a problem, the Bup/Nx dose can be increased to a maximum dose corresponding to the day (see above figure). More rapid inductions of Bup/Nx show favourable outcomes. Due to buprenorphine's long half-life the true effect of a dose may not be evident until the patient has had a particular dose for 3 to 5 days.

An optimal maintenance dose is one where the patient is free of opioid withdrawal symptoms for the full dosing interval without experiencing intoxication or sedation from the medication.<sup>28</sup> At the maintenance dose there will also be an improvement in drug cravings. Cravings will likely not resolve completely with Bup/Nx alone and strategizing around these cravings is an area to focus on during concomitant psychosocial therapy. The maintenance dose may be difficult to predict so generally a careful titration to the effective dose is required.

### **Microdosing and Macro dosing**

Initiations using Microdosing or Macro dosing protocol are not yet fully supported by professional consensus or established clinical evidence (especially Macro dosing). The College does not explicitly prohibit the off-label uses of medication, which may fall under research in clinical trials, evolving clinical practice and, occasionally, complementary and alternative medicine.

Physicians are reminded not to prescribe or practice a therapy that departs from prevailing medical practice unless they are able to demonstrate that the potential benefits outweigh the risks.

### **Less-than-daily dosing**

Following successful induction and after the patient's dose has been stabilized Bup/Nx dosing may be decreased to less-than-daily dosing. Dosing may be decreased to as low as three times per week, for example Monday, Wednesday, and Friday. In this situation, the dose on Monday and Wednesday should be twice that of the daily dose with the Friday dose being 3 times that of the daily dose, with no medication in-between.<sup>29</sup> Even with less-than-daily dosing the maximum dose in each day should not be exceeded. If the patient would require greater than 24mg/6mg Bup/Nx less-than-daily dosing is not an option.

## **Standards**

*This section was adapted from CAMH Clinical Practice Guideline- Buprenorphine/Naloxone for Opioid Dependence<sup>30</sup>*

1. The patient must present in moderate opioid withdrawal prior to initiation of treatment with buprenorphine/ naloxone. The prescriber must perform an assessment of the withdrawal prior to providing the initial dose of Bup/Nx to ensure that moderate opioid withdrawal has been achieved.
2. The initial dose (2-4mg; up to 6mg in clinically required situations but may increase the risk of precipitating withdrawal) must be observed by a physician, pharmacist, or other health care professional to ensure tablet has dissolved.

3. *\*For in-office or pharmacy inductions only\** Precipitated withdrawal must be assessed for within one to three hours of initial dose of Bup/Nx to determine if additional observed doses are necessary (e.g., COWS >8, symptoms of withdrawal)

- One or two 2mg tablets to take home may be provided if repeated observation is not feasible Clear instructions on dose timing must be provided to avoid precipitating withdrawal

Note: It is highly recommended that the efficacy of treatment and general withdrawal symptoms be reassessed 3 to 6 hours after initial dose.

4. *\*For home inductions only\** Written instructions for dosing and timing must be provided to the patient and contact information including afterhours must also be provided so that the patient can reach a member of their healthcare provider team should the need arise.
5. *\*For home inductions only\** A prescriber must check-in with the patient via in-person appointment (clinic visit) or via phone call every day until the dose is stabilized (See definition of clinical stability below) to assess for effectiveness of the dose and side effects. The patient must be made aware that they can present for reassessment earlier if they feel the dose is very inadequate, or if they are having side effects from the dose. Once stabilized it is expected that scheduled office visits occur every one to three months, as appropriate.

Clinical stability:

- No evidence of ongoing problematic substance use, including alcohol
  - No evidence of acute or unstable psychiatric symptoms
  - Stable behaviour and social situation
  - Secure enough housing to safely store the medication.
6. Consider “Microdosing” for patients who cannot tolerate the significant period of abstinence needed to initiate Bup/Nx with a conventional induction (see Appendix V).
  7. Prescribers must ensure the provision of a take-home naloxone kit or a prescription for a naloxone kit for all OAT patients.

## Initiation with Methadone

Patients are at the highest risk of methadone overdose (and overdose death) in the first 2 weeks of initiating treatment with methadone. Most deaths occur during initiation due to rapid dose escalations. Initiation outside of the recommended ranges may result in patient harms, including death. This section outlines the starting dose and subsequent dose increases for patients in the first few weeks of methadone treatment. The initial dose is based on the patient's opioid tolerance and underlying risk for methadone toxicity. It is important to note that methadone can be dangerous, particularly in combination with other CNS depressants or substances that increase serum methadone levels (see **Appendix F** for a list of interacting medications). Rapidly escalating increases in dose bring increased risk and do not necessarily benefit the patient. A clinical assessment is always necessary before adjusting doses because of methadone's long half-life (~24 hours), and slow bioaccumulation.

The risk of increasing a dose in the initiation phase needs to be considered, but it should be noted that increasing methadone doses to effective levels can increase patient retention rates and decrease the use of illicit drugs, alcohol, and psychoactive medications. For information that can be provided to the patient, see **Appendix N** for a resource entitled: *A Patient's Guide – Avoiding Overdose in the First Two Weeks of Methadone Treatment*.

### Standards

1. The risk of methadone toxicity must be assessed by the prescriber prior to initiation. See **Appendix O** for more information related to *Patients at High Risk for Methadone Toxicity*.
2. For patients at **LOW RISK** for methadone toxicity (otherwise well with no respiratory compromise or other acute illness), have tolerance to high-potency opioids from daily use and have UDS confirmation of recent opioid use:
  - a) The starting dose is 30 mg or less.
  - b) The Initiating Prescriber shall prescribe dose increases of no more than 10mg every 3-5 days during the early phase.
3. For patients at **MODERATE RISK** for methadone toxicity (mild respiratory compromise, mild concurrent illness or concerning drug interactions), who have established tolerance via patient history or collateral information, or who have changes in drug metabolism (e.g. over age 65, taking medications that inhibit CYP450 3A4):
  - a) The starting dose is 20 mg or less.
  - b) The Initiating Prescriber shall prescribe dose increases of no more than 10mg every 3-5 days during early phase.
4. For patients at **HIGH RISK** for methadone toxicity, or who have been abstinent from opioids for 7 or more days (moderate respiratory compromise, moderate to severe concurrent illness and/or potential drug interactions see **Appendix F – Drug Interactions with Methadone**), who use intermittently, have unknown tolerance to opioids due to unclear history or lack of

collateral information, or who use low-potency opioids (e.g. codeine):

- a) The starting dose is 10 mg or less.
- b) The Initiating Prescriber shall prescribe dose increases of no more than 5 mg every 5 or more days during the early phase.

Patient Factors	Initial Dose	Dose Increase	Frequency
Low Risk of Methadone Toxicity	30 mg or less	10 mg or less	No more than every 3-5 days during early and late stabilization
Moderate Risk of Methadone Toxicity	20 mg or less	10 mg or less	No more than every 3-5 days during early and late stabilization
High Risk of Methadone Toxicity	10 mg or less	5 mg or less	No more than every 5 days during early and late stabilization

Patients must receive Daily Witnessed Ingestion (DWI) during the initiation phase.

5. Patients must be seen at least once a week during the first 14 days of treatment by the Initiating Prescriber **or** another prescriber with methadone authorization that permits the initiation of methadone for opioid use disorder **or** a member of the treatment team working under the supervision of the Initiating Prescriber who is trained to recognize possible methadone toxicity (e.g. this may include a pharmacist or addiction counsellor).
6. After the first 14 days of treatment, patients must be seen by a prescriber every 1 to 4 weeks until the dose is stable.
7. If the patient shows any sign(s) of instability (see **Appendix P** for Key Indicators of Stability and Instability), the patient must have clinical contact with the Initiating Prescriber or another prescriber with methadone authorization that permits the initiation of methadone for opioid use disorder.
8. Prescribers must ensure the provision of a take-home naloxone kit or a prescription for a naloxone kit for all OAT patients.

## Guidelines

1. Generally, patients should not be on other prescribed opioids during the initiation phase but if withdrawal symptoms indicate SROM may be prescribed in the induction phase for a maximum of 2 weeks. (See **Appendix V–**)

## Stabilization phase in Methadone

*This section details how to manage the stabilization phase, where prescribers work toward a dose and treatment plan to stabilize the patient's condition, social environment, and overall wellbeing. This phase is typically achieved at methadone doses above 60 mg. Patients receiving less are more likely to drop out of treatment prematurely.<sup>31</sup> An effective stabilization dose is reached when withdrawal symptoms are controlled for more than 24 hours and craving for opioids is reduced or eliminated, without causing excessive sedation or other intolerable side effects.<sup>32</sup>\*see **Appendix Q** for more information on reducing risk during stabilization\**

### Standards

1. The Initiating Prescriber must ensure methadone doses are increased only after the patient has been assessed in person, and it is determined that the patient is experiencing cravings or ongoing opioid use, and/or a constellation of withdrawal symptoms.
2. The Initiating Prescriber shall not increase the patient's dose by **more than 10 mg every 5 to 7 days** during the stabilization phase.
3. The prescriber must evaluate the possibility of pregnancy and discuss contraception options regularly, and document this on the patient medical record.

### Guidelines

1. The typical methadone dose to reduce cravings and withdrawal symptoms is between **60 mg to 120 mg**, and as such, most patients should be maintained within this range. When a patient is receiving a dose above 120mg daily, the rationale for the higher dose should be documented on the patient medical record. Note: for patients who use fentanyl regularly, methadone doses of 100mg or higher are often needed.<sup>33</sup>
2. To assess for post-dose sedation at peak serum levels for patients on high doses of methadone, arrange a witnessed dose at the pharmacy, with a follow-up in the clinic 2-4 hours later.
3. Changes to any concurrent medications should prompt a review of the current methadone dosage. Collaboration with a knowledgeable pharmacist is recommended.

## 8. Maintenance Phase in OAT

*When both the dose and the patient are adequately stable, the patient is in the maintenance phase. In this phase, patients receiving methadone therapy may be considered for transfer to a Maintaining (Non-Initiating) Prescriber.*

*The optimal maintenance dose of OAT will relieve withdrawal symptoms, prevent opioid-induced euphoria, and reduce cravings for 24 hours without causing sedation or other significant side effects. The typical dose for buprenorphine/naloxone is **8 to 12 mg** per day, for methadone that range is **60 to 120 mg**; however, higher doses may be required.*

### Standards

1. The Initiating Prescriber must document adequate stability in the patient and the dose for 3 to 6 months before transferring to a Maintaining Prescriber.
2. The Maintaining Prescriber must consult with the Initiating Prescriber before any change in dose and/or if the patient shows more than one indicator of instability. (See **Appendix P**)
3. The Initiating Prescriber must resume care of the patient from the Maintaining Prescriber in the following situations:
  - a) When the Maintaining Prescriber requests a transfer back to the Initiating Prescriber
  - b) When the patient shows more than one indicator of instability
  - c) When the Maintaining Prescriber is unable to provide appropriate care to the patient
  - d) When the pharmacist indicates to the physician that the patient is having issues managing their prescription
4. All patients in the maintenance phase of therapy must have contact with their OAT prescriber every 3 months. Prescriber-to-patient contact may be done remotely.
5. The Maintaining Prescriber should administer a random urine drug screen at a minimum of every 3 months for a stable patient.

### Guidelines

1. For stable patients, the following schedule of clinical visits is recommended:

Length of Time Patient is Stable on OAT	Frequency of Visits with an OAT Prescriber
Less than 6 months	At least monthly
Less than 12 months	At least every 2 months
Greater than 12 months	At least every 3 months

## 9. Slow-Release Oral Morphine (SROM)

*SROM is available for patients whom Bup/Nx and methadone have been ineffective or are contraindicated. Currently, there is no literature to guide treatment decisions beyond the 36-week duration of clinical trials.*

*Beyond the practical use of SROM to mitigate opioid withdrawal during methadone or Bup/Nx induction (Appendix V), the evidence for use of SROM is weak and the risks associated with diversion and overdose are of significant concern. SROM is a non-blocking agonist with limited potential for therapeutic benefit.*

### Standards

1. When there is a lack of experience prescribing SROM, consult an expert prior to initiating treatment as SROM treatment requires diligent measures to avoid overdose and diversion.
2. Review risks and benefits with the patient, obtain informed written consent and ensure rigorous clinical documentation when prescribing SROM.
3. Prescribe SROM as once-daily **witnessed** doses (24-hour formulation) to prevent misuse and minimize diversion risk. Exceptions may be considered if the patient shows exceptional and sustained improvements in clinical and social stability.
4. Start with a one-week titration phase aimed at achieving a stable daily dosage.
5. Separate dosage increases by 48 hours because of the slow-release properties of SROM. Dosing should be based on clinical response, type of ongoing opioid use and risk of leaving treatment.
6. For patients using opioids other than methadone (e.g. heroin), prescribe 30-60mg on the first day and titrate upward according to withdrawal symptoms. Note that some patients who are using illicit fentanyl, doses such as 100-200 mg may be required to retain the patient in care and mitigate withdrawal.
7. For patients who are switching from methadone to SROM, prescribe a methadone-to-SROM dose ratio of 1:4 on the first day (e.g. 60 mg methadone = 240 mg SROM) and titrate upward based on withdrawal symptoms and cravings.
8. The average total daily SROM dose range is 200-800 mg per day.
9. Due to the high risk of diversion and misuse, prescribe take-home doses only in exceptional circumstances, where patients show high clinical stability, or when daily witnessed dosing is a barrier to treatment. Consider gradual take-home dosing on a case-by-case basis, using clinical judgment, appropriate monitoring, and follow-up. Take-home doses should not be permitted for doses more than 200 mg and should only be provided at maximum weekly intervals.

## 10. Spoiled, Lost and Missed Doses

*This section outlines how prescribers and pharmacists must manage spoiled (e.g. spilled doses, broken bottles), lost, or missed doses. Compliance with dosing is important for the success of OAT programs. Missed doses will contribute to a loss of tolerance to either drug. The tables below outline the protocol to deal with missed doses of OAT.*

*For methadone specifically, there is a greater risk associated with missed doses. When there is uncertainty about whether a dose had been spoiled, lost, vomited, or missed, it is important to remember that the risk of death from overdose is much greater than the risk of harm from mild withdrawal symptoms. Ongoing communication and collaboration between the prescriber and pharmacist are essential. Rapid decline in tolerance to methadone necessitates careful management of missed doses, as failure to adjust a dose in this context can result in overdose and/or in death.*

### Standards (Buprenorphine/naloxone specific)

1. Replacement doses must be given **only** as witnessed ingestion.
2. All reports of lost or missed doses must be documented on the patient's medical file.
3. Communication with the Initiating Prescriber must occur for all missed doses, regardless of cause, duration, or number.
4. Patients should not receive buprenorphine/naloxone if they appear to be intoxicated, particularly with alcohol; patients may be asked to wait to be reassessed some hours later prior to administration of therapy.

Buprenorphine/Naloxone missed doses protocol <sup>34</sup>		
Buprenorphine Dose	Number of Consecutive Days Missed	New Starting Dose*
>8mg	>7 days	4mg
>8mg	6 to 7 Days	8mg
6 to 8mg	6 or more days	4mg
2 to 4mg	6 or more days	2 to 4mg

\*Be sure to consider any opioid consumption to avoid precipitated withdrawal

## Standards (Methadone specific)

1. If the patient has observed emesis by a health care provider within 15 minutes of an observed dose, offer one replacement dose of methadone (no more than 50% of the regular dose).
2. Unwitnessed vomited doses must not be replaced without consultation and documentation. Methadone absorption typically occurs within 30 to 60 minutes of ingestion. No dose replacement is required after one hour.
3. All reports of vomited, lost or missed doses must be documented on the patient's medical file.
4. Replacement doses must be given only as witnessed ingestion.
5. Communication with the Initiating Prescriber must occur for all missed doses, regardless of cause, duration, or number.
6. If a patient misses 2 of 7 non-consecutive doses, the patient must be re-assessed by the prescriber.
7. Patients should not receive methadone if they appear to be intoxicated, particularly with alcohol; patients may be asked to wait to be reassessed some hours later prior to administration of therapy.

Methadone missed doses protocol <sup>35</sup>	
Missed Days (Consecutive)	Suggested Dose Adjustment
1 to 2	Same dose (No change) unless there are concerns about loss of tolerance or adverse events
3	Restart at 50% of previous dose
4+	Restart at 5 to 30 mg (depending on tolerance)

Re-establish a stable methadone dose in cases of several missed doses, as appropriate; this may not be the same as the previous dose.

## 11. Random Urine Drug Screening (RUDS)

*Random Urine Drug Screening (RUDS) is the analysis of urine for the presence of medications and illicit drugs or their metabolites. RUDS is not used punitively; rather, it is used as one tool in a comprehensive risk assessment to provide information about exposures and risks, promote patient safety, guide care decisions such as adequacy of dose, and monitor progress toward treatment goals. For example, RUDS shows compliance with OAT and that, in turn, may be beneficial for maintaining/regaining custody of a child.*

*More information on how to administer and use RUDS can be found in this [Doc Talk article](#). In addition, different substances may be detected in the urine for a variable period after their use depending on the type of lab methodology used. Information regarding RUDS processes can be found in **Appendix R**. Information on the metabolic pathway of various opioids and benzodiazepines can be found in **Appendix S**.*

*For additional information on laboratory testing techniques, contract the Roy Romanow Provincial Laboratory (Formerly Saskatchewan Disease Control Laboratory) by phone: 306-787-3131 or visit*

*<https://www.saskhealthauthority.ca/facilities-locations/roy-romanow-provincial-laboratory-rrpl>*

### Standards

1. An OAT program must include random screenings: that is urine drug screens that are unscheduled with no fixed dates and where the patient has no more than 24 hours' notice that a urine collection is required.
2. RUDS must be done by provincial lab (gas chromatography/mass spectrometry).
3. Frequency of collection is as follows [or more frequent as required if there are safety concerns (e.g. relapse, diversion)]:<sup>36</sup>
  - a) Initiation: at least one UDS before a patient is initiated (see *Patient Assessment for Admission to an OAT Program* in section 5)
  - b) Stabilization: assess substance use weekly during stabilization; this may involve RUDS if the clinical assessment, including history, requires supplementary lab investigations
  - c) Maintenance: collected at least every 3 months
  - d) For patients requiring take home doses or carries<sup>37</sup>
    - I. 8 RUDS in a year for methadone
    - II. 4 RUDS in a year for buprenorphine/naloxone

4. RUDS results containing either illicit substances, prescription medications not prescribed to the patient, or an absence of the OAT medication must prompt prescribers to evaluate the withdrawal of take-home carries, increasing the frequency of RUDSs, and the return of the patient back to the Initiating Prescriber, for those on methadone.
5. If the patient has provided a tampered urine sample or has failed to attend a requested RUDS within 24 hours (48 hours in occasional exceptional circumstances), this behaviour is considered equivalent to a RUDS result containing either illicit substances, prescription medications not prescribed to the patient, or an absence of the OAT medication.
  - Counsel patients who do not attend a RUDS within 24-48 hours of a request for specimen collection about the value of RUDS to the treatment plan and take measures to facilitate testing if there are barriers
  - If a patient provides a tampered specimen, seek to understand the patient's concerns about RUDS and explore ways to help them feel comfortable discussing substance use and to make RUDS useful to both the patient and clinician
6. A prescriber must consult with PIP or eHealth viewer, or another reliable source for medication information, to ensure medications that are being prescribed are shown in the lab results, and to be aware of other medications that may be concurrently prescribed by other prescribers.

## Guidelines

1. Consultation with the provincial laboratory performing the testing should be considered if a result requires clarification or follow-up discussion.
2. Laboratory results may be shared with primary care providers or specialists. Care should be taken to ensure patient privacy is maintained.
3. More frequent urine drug tests are not necessarily required (given ongoing treatment and regular clinical visits are provided) if ongoing substance use is fully disclosed by the patient.

## 12. Electrocardiograms (ECGs) for Patients Prescribed Methadone

*Methadone may prolong the QTc interval and result in Torsade de Pointes, resulting in greater risk of mortality. Lack of ECGs is not a barrier to receiving OAT. If ECGs are not readily available, prescribers must use clinical judgment to guide decisions about initiating OAT.*

### Standards

1. Initiating Prescribers must make all possible efforts to obtain an ECG at initiation to measure the QTc interval.<sup>38</sup> A follow-up ECG should also be done 30 days following initiation of methadone therapy. Prescribers must document all requests made of the patient to obtain an ECG regardless of if the patient complies.
2. All efforts must be made to obtain an ECG annually for patients treated with methadone. Prescribers should document in the patient medical record when this request is made of the patient regardless of if the patient complies.
3. An effort must be made to obtain additional ECGs in the following situations:
  - Family history of prolonged QTc or sudden death
  - Patient has had previous arrhythmias/hospitalizations (e.g. Torsades de Pointes syndrome)
  - If the methadone dose meets or exceeds 120 mg, and thereafter at every dose that meets or exceeds a multiple of 20mg (e.g., 120 mg, 140 mg, 160 mg);
  - If the patient has unexplained syncope, presyncope, palpitations, blurred vision or seizures, or other symptoms that are suggestive of cardiac involvement;
  - When a patient is initiated on (or already takes) medications known to prolong the QTc interval;
  - Patient is using illicit substances known to prolong the QTc interval (e.g. cocaine, crystal methamphetamine)
4. If the QTc interval is greater than 450 msec, but less than 500 msec, prescribers must review the potential risks and benefits with patients and monitor them more frequently, including more frequent ECGs. There is an increased risk of cardiac dysrhythmia as the QTc exceeds 450 msec. This discussion with the patient and subsequent requests for additional ECGs must be documented on the patient medication record.
5. If the QTc interval exceeds 500 msec, the prescriber must carefully consider the risks and benefits of continued treatment at the current dose, and discuss alternatives with the patient, including discontinuing or reducing the methadone dose, or eliminating contributing factors or medications. Discuss alternative agonist therapy (e.g. buprenorphine). Check and manage electrolyte abnormalities (including hypokalaemia, hypomagnesemia, hypocalcaemia). Consult a cardiologist if necessary. This discussion with the patient must be documented on the patient medication record.

6. Medications must be reviewed prior to initiation of methadone and on a regular basis to identify any medications that are known to prolong the QTc interval, in an effort to reduce risk.
7. If QTc prolongation is identified, the patient's other prescribers must be advised of this issue and encouraged to avoid medications that have the potential to prolong the QTc interval.

## 13. Split Dosages of Methadone

*Split doses are occasionally used in the management of pregnancy, acute/chronic pain, and for patients who are on medications that induce rapid metabolism of methadone.*

### Standards

1. The prescribing and dispensing of split dosages of methadone must be supported by documented withdrawal signs and symptoms within 24 hours of the daily dose, and/or signs and symptoms of excessive methadone dose in the four hours following a single daily dosage.
2. Patients requiring split doses must either attend the pharmacy twice a day or be eligible for carries. (*See Section 14 on carries*)

### Guidelines

1. Split dosages may rarely be required under certain clinical conditions. In these situations, it is recommended that prescribers consult with an expert in addiction medicine.
2. Rapid metabolizers of methadone are rare; evaluation of the peak and trough serum methadone level, or calculating the half-life, is recommended.
3. Twice-daily observed ingestion may be necessary and depends on a thorough risk assessment, including patient retention consideration.
4. Split doses do not necessarily have to be equal. A lower dose of  $\frac{1}{4}$  to  $\frac{1}{3}$  the total daily dose, provided as a carry, may be satisfactory to the patient, and reduce the amount of methadone prone to diversion or misuse.

## 14. Carries

*This section outlines the parameters for patients carrying take-home doses of OAT medications. Take-home doses are referred to as “carries”. The decision to permit carried doses must consider the safety of the patient and the community. Patients cannot be granted carries until adequate stability is achieved and the risks vs. benefits have been carefully assessed. It is important to recognize that some patients may never achieve adequate stability due to underlying mental illness, co-existing addictions, or social conditions such as unstable housing. Carry privileges require evidence of functional progress. See Take Home Dose Agreement in **Appendix T** for a sample of an agreement for prescribers and patients to discuss.*

*Serious harm to the patient and others can result from inappropriately used, lost, stolen or spoiled carries (especially with methadone). Patient requests for replacements may indicate clinical instability and necessitate a thorough clinical evaluation. Decisions to replace doses should be made only after diligent consideration and evaluation of the risks and benefits.*

## *Criteria for initiating OAT carries*

An assessment of the patient's stability factoring in what the patient self-reports, information from social supports, other healthcare providers, physical exam, interview, RUDS, and medication adherence information should be done prior to providing carries.<sup>39</sup> There is an increased risk of overdose when OAT is combined with other depressants such as benzodiazepines or alcohol. Although the assessment for take home dosing of Bup/Nx and methadone is similar, each medication possesses different public safety risks.<sup>40</sup> Bup/Nx is safer and thus, deaths associated with its use are uncommon. For that reason, the implementation and use of take-home dosing as part of an OATP should be more commonplace with Bup/Nx treatment vs methadone treatment.

When authorizing carry privileges, a prescriber should begin with narrow parameters that can be expanded or restricted based on the patient's stability. Progressive carry privileges should be dependent on increased stability and discontinuation or reduction in carry privileges should occur with evidence of instability.<sup>41</sup>

Prerequisites for carries:<sup>42</sup>

- Patients should achieve clinical stability before receiving take-home doses of Bup/Nx or methadone.
- Patients should demonstrate social, cognitive, and emotional stability, including absence of suicidal ideation and psychosis; attendance at scheduled appointments; absence of missed doses and improved social relationships, stable housing, and/or return to work or school.
- RUDS are also an important measure and should demonstrate the safe and appropriate use of OAT medications.

Safe storage prerequisites:<sup>43</sup>

- Patients must be educated on the dangers (including overdose and death) that the medications pose, especially for patients who are opioid-naïve and children. Ensuring the patient understands the importance of safe storage.
- Bup/Nx and methadone should be stored in child-proof containers and methadone requires lock boxes. Carries are not to be provided if safe storage cannot be ensured.

Witnessed ingestion recommended in the case of:

- Potential for promotion of patient safety and treatment adherence via increased contact with a health care provider.
- Homelessness or other reason for no safe storage space.
- Evidence of diversion of medication.
- Ongoing substance use especially related to benzodiazepines, alcohol, and other sedatives.
- Length and track record of clinic attendance (e.g., poor appointment attendance).
- Severe behavioural issues (e.g. disruptive or violent behaviour), cognitive impairment or unstable mental health.

### Buprenorphine/naloxone considerations:

Take-home doses of buprenorphine/naloxone can be provided at any time at the discretion of the prescriber, if benefits outweigh the risks and can safely store the medication. A quick transition to take-home dosing has been shown to improve treatment adherence and retention. Generally, when offered, take-home dosing is provided for one or two weeks' worth of medication at a time. Considerations can also be given to provide take home buprenorphine/naloxone doses during induction when multiple same-day visits are not possible.

It is important to note that daily witnessed ingestions may be a reason for patient drop out, but this must be balanced against the risks of harms.

### Standards (Buprenorphine/Naloxone specific)

1. Take home doses must not be initiated until the patient has shown clinical stability, with special caution shown if patient has been suicidal, injecting, has cognitive impairment or unstable housing.
2. All efforts must be made to ensure that patients prescribed medications with potentially harmful interactions such as benzodiazepines, other CNS depressants, including other opioids, are not granted carries.
3. Prescriptions must clearly define witnessed ingestion days and carry intervals.
4. Prescribers must clearly document any decision to provide a patient with carries.
  - a) If carried doses are granted in an exceptional situation, the prescriber must evaluate the risks and document the rationale for the decision to grant carries.

*Special considerations may be given if the patient has 2 months of appropriate urine drug screens and documented employment, education, childcare responsibilities, or physical disability.*

5. All carries must include a witnessed ingestion. There may be rare, exceptional circumstances where witnessed ingestions with carries cannot occur. In these situations, prescribers must consider:
  - a) The patient's circumstances;
  - b) Storage of Bup/Nx carries; and
  - c) The environment in which they live and work.

6. There must be a gradual increase in the number of take-home doses up to a suggested maximum of one to two weeks of consecutive take-home doses dispensed between observed doses.
7. Take home doses must be reduced or eliminated in response to a loss of clinical stability. If a high level of take-home doses is eliminated all at once, and diversion is suspected, the prescriber must consider reducing the buprenorphine/naloxone dose by 25% to 50%.
8. The Prescriber must be satisfied that carried doses will be securely transported and stored by the patient.
9. Inappropriately used, lost, stolen, or spoiled carried doses require complete withdrawal of carry privileges until adequate clinical and social stability is established. Replacement dosing is provided only as a daily witnessed ingestion. Resumption of carry privileges after reports of inappropriately used, lost, stolen, or spoiled carried doses should consider the circumstances of the incident, as well as the patient's clinical and social situation.
10. Facilitate guest dosing (i.e. arranging for the patient to temporarily receive their dose from a different pharmacy) when take-home dosing may not support treatment safety and effectiveness or where the patient is unable to attend their regular pharmacy for an extended time.

### Methadone Considerations:

Due to the increased risk of overdose, and diversion, methadone should be prescribed as daily witnessed doses ingested under the supervision of a pharmacist. More restrictive criteria must be met before methadone can be given as take-home doses due to public safety risk. Decisions for carries and their rationale must be clearly documented by the Prescriber.

### Standards (Methadone specific)

1. Take home doses must be prescribed incrementally beginning at a rate of 1 to 2 doses per week, to a maximum of 6 take-home doses per week.
2. Prescriptions must clearly define witnessed ingestion days and carry intervals.
3. Carries must not be granted in the initiation and stabilization phase. Carries can only be prescribed when adequate clinical and social stability have been achieved and documented. Exceptions may only be made when the pharmacy is closed or in exceptional circumstances.
4. Carries cannot be granted until the patient has at least 2 consecutive months of clinical stability (including reassuring RUDS results).

5. The prescriber shall not prescribe take-home doses if:
  - a) The patient is at risk of taking more than prescribed;
  - b) The patient is not able to safely store the methadone;
  - c) There is suspicion that the patient is diverting methadone; or
  - d) There is continued use of prohibited drugs and other potentially harmful interacting substances such as alcohol or other CNS depressants.
6. All efforts must be made to ensure that patients on methadone who are prescribed medications with potentially harmful interactions such as benzodiazepines, other CNS depressants, including other opioids, are not granted carries without very careful consideration the risks and benefits, along with discussion and documentation of the considerations. See **Appendix F** for a list of interacting medications.
7. All carries must include a witnessed ingestion. There may be rare, exceptional circumstances where witnessed ingestions with carries cannot occur. In these situations, prescribers must consider:
  - a) The patient's circumstances;
  - b) Storage of methadone carries; and
  - c) The environment in which they live and work.
8. Prescribers must clearly document any decision to provide a patient with carries.
  - a) If carried doses are granted in an exceptional situation, the prescriber must evaluate the risks and document the rationale for the decision to grant carries.

*Special consideration may be given if patient has 2 months of appropriate urine drug screens, documented employment, education, childcare responsibilities, or physical disability.*
9. The prescriber must be satisfied that carried doses will be securely transported and stored by the patient.
  - a) A locked box or storage container for any carried doses is required, and empty bottles must be returned to the pharmacy for proper disposal.

10. The daily observed dose must be reduced if the prescriber suspects the patient may not have been taking the full take-home dose. The prescriber shall cancel all carry privileges immediately when any of the following circumstances occur:
- a) There is reasonable suspicion that the patient has diverted their methadone dose, has tampered with their RUDS, or prescription bottles (Carry bottles of methadone must be returned intact, and not tampered with [i.e. labels intact]);
  - b) The patient has relapsed by self-report, observed intoxication or RUDS result containing either illicit substances, prescription medications not prescribed to the patient, or an absence of the OAT medication;
  - c) The patient has unstable housing, and can no longer safely store their methadone;
  - d) The patient is actively suicidal, cognitively impaired, psychotic, or is otherwise at risk for misuse of their methadone dose; or
  - e) The patient has recently been released from a correctional facility. (DWI from release day until assessed by the community-based prescriber. If assessed as stable, then they may resume carries. Incarceration is normally viewed as a marker of instability).
11. Inappropriately used, lost, stolen, or spoiled carried doses require complete withdrawal of carry privileges until adequate clinical and social stability is established. Replacement dosing is provided only as a daily witnessed ingestion. Resumption of carry privileges after reports of inappropriately used, lost, stolen, or spoiled carried doses must consider the circumstances of the incident, as well as the patient's clinical and social situation. A cautious and conservative approach is recommended.
12. Facilitate guest dosing (i.e. arranging for the patient to temporarily receive their dose from a different pharmacy) when take-home dosing may not support treatment safety and effectiveness or where the patient is unable to attend their regular pharmacy for an extended time.

## 15. OAT & Other Medications

*Medications used in OAT have the potential to interact with a variety of other medications via numerous differing pathways. Unmanaged drug-drug interactions may cause preventable morbidity, mortality, and hospitalization. Special care should be taken in assessing the interaction risk of OAT medications with other prescribed medications. Prescribers should also keep in mind the potential of harm related to interactions with non-prescribed, or illicit drugs.*

### Standards

Prescribers must be familiar with other medications that may interact with OAT medications resulting in possible prolongation of the QTc interval, and/or CNS depression, and/or inhibition or induction of systems involved in the metabolism of the medications. See **Appendix F** for more information related to OAT and possible drug interactions.

1. A prescriber must consult with PIP, eHealth viewer, or another reliable source for medication information as a part of their ongoing patient management, to be aware of and manage potential drug interactions as they arise.
2. Prescribers must advise patients about the interactions of benzodiazepines, gabapentin/pregabalin, and other opioids with OAT medications. Information provided to patients must include education regarding risk of fatal overdose. This discussion must be documented on the patient medical record.
3. Caution must be exercised in prescribing benzodiazepines in OATP, and a patient's history, examination findings and diagnoses leading to treatment with benzodiazepines must be well documented.

### Guidelines

1. If the risk of continuing to prescribe OAT outweighs the benefits, the prescriber should discontinue treatment (this is of particular importance in the incarcerated population). Maintaining Prescribers must consult with the Initiating Prescribers as necessary.
2. Patients who are prescribed methadone for the ongoing management of concurrent chronic pain and OUD need a comprehensive management plan. With such patients, the advice of a physician with a specialized training in chronic pain should be sought out.

## 16. Discontinuation

*\*\*The section below is taken from the College of Physicians and Surgeons of British Columbia- Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder.<sup>44</sup>*

There is evidence to support that patient who remain in long-term OATPs continue to derive benefit. Success of treatment is directly proportional to the length of time on treatment. Most patients who discontinue OAT prematurely are at risk of relapse to non-medical opioid use within one year. Abrupt cessation of either medication can lead to severe withdrawal symptoms which cause emotional and physical distress and can in turn lead to relapse or unintentional overdose. Buprenorphine is associated with lower intensity of withdrawal symptoms, when discontinued. At the beginning and end of treatment, patients are particularly vulnerable to relapse. Discontinuation of treatment should not result in disruption of patients' use of available primary care or mental health services.

## A. *Involuntary Withdrawal*

Involuntary withdrawal should be considered when continuation of treatment presents unreasonable risk to the patient, treatment staff, prescribers, pharmacy staff or the public. Dismissal does not mean that patients should not be considered for readmission to the program later.

### Standards

1. The Initiating/Maintaining Prescriber may transfer or cease OAT to a patient if:
  - a. The patient has been threatening or disruptive, or has shown violent behaviour toward a staff member or others;
  - b. The patient is consistently non-compliant with the treatment agreement;
  - c. The patient is at high risk for adverse outcomes and attempts to reduce the risk have failed; or
  - d. The patient is believed to have diverted their methadone prescription; or
  - e. The patient is incarcerated and receiving care from another provider.
2. All doses during involuntary withdrawal must be Daily Witnessed Ingestion, with no carries, except as pharmacy closure requires.
3. Involuntary withdrawals result in instability and withdrawal must be managed by an Initiating Prescriber only (Note: this does not apply to individuals who are incarcerated). Maintaining Prescribers of a patient who must be involuntarily withdrawn from OAT must transfer the patient back to an Initiating Prescriber who will manage their withdrawal and ongoing care.
4. The Initiating Prescriber must warn the patient about the loss of tolerance and the risk of toxicity if they relapse to opioids.
5. Prescribers must ensure the provision of a take-home naloxone kit or a prescription for a naloxone kit for all patients on OAT.

### Guidelines

1. The Initiating/Maintaining Prescriber should explain the reasons for cessation to the patient and document the rationale.
2. The Initiating Prescriber may use pharmacotherapy in the final 1 to 2 weeks of the OAT decrease to relieve withdrawal symptoms. See **Appendix M** - Opioid Withdrawal and Tolerance.

3. The Initiating/Maintaining Prescriber should encourage the patient to engage with other health care professionals or an addiction treatment program for counselling and support.

An example of an aggressive schedule for an involuntary withdrawal is as follows:

- a 10% reduction of the daily dose per day, or 1 mg per day, whichever is greater. This schedule results in complete cessation within 30 days for any dose under 150 mg, and within 40 days for any dose less than 500 mg.

## *B. Voluntary Withdrawal*

This section outlines how to manage a patient's voluntary withdrawal from OAT. Optimum benefit from OATPs is not realized for at least a year. Generally, patients who have been in programs for two to three years will have better outcomes than those who start the tapering process before two years of treatment. To reduce risk of relapse, patients should be encouraged to stay in OATP but ultimately, it's the patient's choice. Patients who continue to benefit from Bup/Nx or methadone naloxone and do not wish to be tapered should not be pressured to do so.

Any change in OAT dose, including voluntary tapering, may increase the risk of instability. It is prudent to discuss the preparation for this process with the patient, including ongoing or enhanced counselling or a reduction in the number of carried doses. See tapering readiness questions in **Appendix U**.

### Standards

1. Prescribers must warn the patient about the loss of tolerance and the risk of toxicity if he/she relapse to opioids. This discussion must be documented on the patient medical record.
2. Prescribers, or a member of the treatment team working under the supervision of the Prescriber who is trained to recognize withdrawal (e.g. nursing staff), must see the patient regularly during withdrawal to assess the patient's mood and withdrawal symptoms, and provide supportive counselling.
3. Prescribers must ensure the provision of a take-home naloxone kit or a prescription for a naloxone kit for all patients on OAT.

### Guidelines

1. For voluntary tapers, the prescriber should taper patients slowly, however, the rate of the taper should be patient-driven, even if the patient desires a more rapid taper.
2. Suggest attempting periodic tapers for patients on high OAT doses (e.g. >24 mg of Bup/Nx or 120 mg of methadone) if there is a low risk of relapse and the patient has been stable for at least one year.
3. The prescriber should offer to follow the patient for at least a few months after the completion of the decrease.
4. The prescriber should offer to reinstate OAT if the patient requests it during voluntary withdrawal.
5. Maintain an "open door" approach to care so that the patient feels welcomed back in case of relapse or if further support is required.

6. The prescriber may use non-opioid pharmacotherapy to relieve withdrawal symptoms. See **Appendix M** - *Opioid Withdrawal and Tolerance*.
7. The prescriber should encourage the patient to continue to engage with other health care professionals or an addiction treatment program for counselling and support.

## 17. Transfer of Care

*This section outlines the requirements of prescribers transferring a patient to another prescriber, whether the patient is being transferred between OATPs or from an Initiating Prescriber to a Maintaining Prescriber. Patient convenience and preference must not outweigh concerns for patient, and community safety. Patients who are high risk, are not adequately stable, and do not yet have a stable dose should not be transferred to a community that does not have a pharmacy open 7-days a week (especially when treated with methadone).*

### Standards

1. The current Prescriber must provide sufficient information on the patient and their treatment plan at the time of transfer and anytime thereafter to the new Prescriber to permit the safe and effective continuation of OAT, including:
  - a. the dose of OAT
  - b. all prescribed medications
  - c. details on how many carries are permitted
  - d. frequency of RUDSs
  - e. a copy of the treatment agreement
  - f. relevant clinical history of the patient (including current recovery status)
  - g. contact information for the Initiating Prescriber
2. The Initiating/Maintaining Prescriber must continue to provide services to a patient until they are no longer required or desired, or until involuntary withdrawal is completed.
3. When an Initiating/Maintaining Prescriber is closing their practice, they must initiate a transfer of care and assist the patient in finding alternate OAT services.
4. If a patient is stable and is moving to a community where they cannot access pharmacy open 7 days a week and is receiving DWI, the Initiating/Maintaining Prescriber and the local pharmacy must collaborate on a treatment plan prior to the patient transferring to the new community.
5. Patients who continue to be high risk, as they are not adequately stable and are not on a stable dose of OAT, must not be transferred to a Maintaining Prescriber or to a community that does not have reasonable pharmacy access.

### Guidelines

1. When a patient in an OATP moves to another community, region, or country, it is the patient's responsibility to arrange OAT services. However, the current Initiating/Maintaining Prescriber should provide reasonable assistance to the patient.

## 18. Special Situations: Incarceration

*Necessary medical treatment, including OAT, should be provided to any individual incarcerated in a provincial correctional or remand centre. There is a safety concern regarding opioids and other addictive medications used in correctional facilities. These drugs are highly desirable and might, as a result compromise the safety of inmates and staff. Caution should be used offering a patient OAT in this environment, with special care taken to manage the risk of diversion.*

*It is important to note that when working in corrections, the patient population is at unique safety risk. Upon release from a correctional facility, patients are at an extremely high risk of overdose for the first fourteen days.<sup>45</sup> Despite the zero-tolerance drug policy of the Correctional Service of Canada, drug abuse is rife in prisons. Substance use is especially dangerous in corrections due to the restricted access of misused drugs, diversion, and hoarding of medications for multi-dosing, all of which increase the risk of overdose.<sup>46</sup> Furthermore, individuals who do not have access to their usual drug of choice will seek out other less familiar medications to compensate. A zero-tolerance policy also makes risky behaviours such as needling sharing, and the use of makeshift needles a concern. These practices, among others, contribute to the high rates of HIV and HCV in this patient population.<sup>47</sup> It is well documented that initiation or continuation of therapy while incarcerated results in reduced mortality, reduced re-incarceration rates and lower incidence of hepatitis C infection.<sup>48</sup>*

*Although there are many challenges in providing care for incarcerated individuals, there is also an opportunity to reach out. Past Saskatchewan reports have indicated that a very high proportion of provincial offenders were identified as having a substance use problem.<sup>49</sup> It is likely that patients in corrections are great candidates for substance use interventions, due to their circumstances access to drugs of abuse is limited, it is easy for those in the circle of care to follow up and monitor individuals, and the individuals themselves might be highly motivated and receptive to implement change. Knowing there is an increased rate of substance misuse, it is important to consider harm reduction strategies (access to naloxone kits, especially upon release), and initiation of OAT for patients both at time of incarceration, and time of release.*

### Standards

1. The prescriber providing OAT to the patient at the time of incarceration must provide all information necessary for safe and effective OAT upon the request of the correctional or remand centre.
2. Prescribing of OAT is only for the duration of the patient's incarceration. However, upon release from a correctional facility, the Prescriber must ensure continuity of care for an OAT patient and provide an appropriate OAT prescription to prevent an interruption of therapy (i.e. must provide a prescription of duration sufficient to last the patient until they can contact their regular OAT clinic during regular business hours OR until the patient can attend their appointment with the community-based prescriber).

3. Prior to the patient's discharge from a corrections facility, the Prescriber must collaborate with the Initiating or Maintaining Prescriber on:
  - a) Discharge plans,
  - b) Any changes in dosage, and
  - c) The prescribing of short-term opioid analgesics, psychoactive or medications with the potential to interaction with OAT. For patients discharged from federal intuitions, medications prescribed and dispensed during admission do not appear on the PIP and communication between providers is essential to ensure continuity of care and prevent medication errors.
4. The prescriber providing OAT to the patient at the time of incarceration will resume OAT at the time of release unless other arrangements have been made. Under extraordinary circumstances the prescriber may continue to prescribe during the incarceration.
5. Prescribers must ensure the provision of a take-home naloxone kit or a prescription for a naloxone kit for all OAT patients upon discharge from a correctional or remand centre.

## Guidelines

1. Patients entering a provincial correctional or remand centre who are on a stable dose of OAT should be maintained on an appropriate dose for the duration of their incarceration, except where patient behaviour incurs involuntary withdrawal as outlined in *Section 15: Discontinuation: Involuntary Withdrawal* of this document or where clinical assessment determines the need for a dosage change.

## 19. Special Situations: Adolescents (<18 years)

*OUD is a growing concern in youth populations, estimates of OUD prevalence among youth in Canada are lacking, and the 2017 Ontario Student Drug Use and Health Survey found that 10.6 % of students' grade 7 to 12 had used non-prescribed opioids in the past year.<sup>50</sup> This might be because youth are more likely to experiment with the use of pharmaceuticals due to perceived safety versus illicit drugs. These attitudes might play a role in diversion of medications, even from their own homes. Also due to their age youth may be more challenging to treat because they could be less motivated to undergo treatment, because they suffer from less negative side effects than other users because of their age, and amount of time on opioids.*

**Risk factors** that may predict adolescent substance use are:

- Mental health disorders
- Family history of substance use or mental health disorders
- Family dysfunction
- Either excessively permissive or conversely overly rigid parenting styles
- Childhood sexual abuse
- Street involvement

A child need not reach the age of majority to give consent to treatment. The determining factor in a child's ability to legally provide or refuse consent is whether their physical, mental, and emotional development allows for a full appreciation of the nature and consequences of the proposed treatment or lack of treatment.<sup>51</sup>

If a child can provide informed consent to treatment, the physician can only involve the child's parent or guardian with the consent of the patient or if the physician concludes that disclosing the child's personal health information will avoid or minimize a danger to the child's health or safety.<sup>52</sup>

Physicians who provide care to adolescents with OUD should be familiar with the guidance provided by CMPA on how to assess whether the adolescent has the competence to consent to treatment.<sup>53</sup>

In providing care for OUD patients who are adolescents, special care should be taken, and treatment initiation should be limited to prescribers who have the knowledge, skills, and resources to treat specific populations. It is recommended that a full range of treatment options be available to youth in need of treatment. Furthermore, treatment should be developmentally appropriate, youth-centred, trauma-informed, confidential, and include family involvement

whenever possible or appropriate.<sup>54</sup> Treatment should be tailored to the patient and individualized whenever possible. Recovery oriented care, with the goal of complete cessation of opioid use should be an option for these individuals, with early intervention preferred. In addition to that, treatment and intervention plans should include services in other domains (e.g. vocational, educational, recreational, medical, family, and legal).<sup>55</sup>

Buprenorphine/Naloxone is first-line for treatment of adolescents, but it is important to note that this would be considered off-label use due to age, and lack of evidence. Induction, stabilization, and maintenance dosing of OAT is like that in adults. The pharmacotherapy decisions are like adults, including the structure and safety measures of OATP.<sup>56</sup> The psychotherapeutic approaches, however, may differ. Treatment approaches should include non-confrontational techniques, and the expectation of erratic attendance and retention.<sup>57</sup> Appropriate involvement of family supports, referral or sessions to address other needs of adolescents (e.g. educational, vocational, housing, STIs, HIV, and pregnancy prevention, and skills training needs) are encouraged. A prescriber should understand when referral for counselling, psychiatric assessment, and psychotherapy is required.<sup>58</sup>

It is recommended that all youth with OUD be assessed for co-occurring disorders (specifically regarding mental health). Patients in this population should be offered referrals to a specialist as needed and treatment when appropriate. Psychosocial support should be offered to all youth with OUD and if there are potential barriers to accessing care they should be addressed.<sup>59</sup>

### **LGBT2Q+**<sup>60</sup>

Lesbian, gay, bisexual, trans, and sexually diverse individuals (LGBT2Q+) face unique challenges that should be addressed when providing care. LGBT2Q+ individuals report disproportionate rates of substance use and enter treatment with greater severity of substance use problems. Suggested explanations for these disproportionate rates include the stress of being in a minority group, dealing with social prejudice and discrimination, internalized stigma, and lack of cultural competence in the health care system. Strategies for working with LGBT2Q+ youth include actively communicating those services are available for LGBT2Q+ clients, establishing contacts within the LGBT2Q+ community, and using inclusive language in forms and clinical materials.

### Useful resources:

#### **Out Saskatoon**

*This page is for medical professionals in Saskatoon and Saskatchewan who need educational resources on the queer community.*

[https://www.outsaskatoon.ca/resource-library/?sfm\\_resource\\_audience=Professionals](https://www.outsaskatoon.ca/resource-library/?sfm_resource_audience=Professionals)

#### **Canadian Paediatric Society position statement: Adolescent sexual orientation**

<https://cps.ca/documents/position/comprehensive-sexual-health-assessments-for-adolescents>

#### **Canadian Paediatric Society position statement: Reducing risky health behaviours in adolescents**

<https://www.cps.ca/en/documents/position/harm-reduction-risky-health-behaviours>

## **Confidentiality**

As with all medical care, confidentiality requirements should be followed even with persons under 18 years of age. This includes maintaining confidentiality from the youth's parent(s) or legal guardian(s) unless otherwise specified.<sup>61</sup> There are positives associated with including the patient's family in care, and they could serve as a support but ultimately the individual's wishes are to be respected.

## **Standards**

1. The prescriber must screen for mental health before initiation of OAT treatment.
2. The prescriber must consider abstinence-based treatment for patients under 18 years of age.
3. Education, and provision of take-home naloxone kits or a prescription for a naloxone kit must be offered for all adolescent patients who may benefit from such services.
4. The Initiating Prescriber must consult with another OAT provider prior to initiating OAT in a patient under 18 years of age.
5. *\*Only for patients receiving methadone\** The Initiating Prescriber must ensure there has been a discussion with patients under 18 years of age (and other family members where appropriate, and with the consent of the adolescent if required) about the potential issues with methadone, including side effects, risks and difficulty withdrawing and tapering off methadone.

## 20. Special Situations: Pregnancy

*Menstrual irregularity and amenorrhea are commonly experienced adverse events in women who are opioid dependent. Once stabilized on OAT these issues will be regulated and ovulation will likely resume. Women of childbearing age should receive a pregnancy test on initial visit and periodically thereafter.<sup>62</sup> Prescribers should be aware that methadone can interfere with urine testing for pregnancy.<sup>63</sup> Birth control should be offered to all women upon initiation of buprenorphine or methadone. Depo-Provera and progesterone-impregnated intrauterine devices (IUDs) are the least expensive and the most reliable option in this often-unstable population. Oral contraceptives can be taken daily with methadone to reduce missed doses. All women of childbearing age in OATP should be given advice about contraception and risks and benefits of becoming pregnant while on OAT. When stable non-pregnant women suddenly feel the need to increase their methadone or buprenorphine dose, consider the possibility of pregnancy as a potential reason for the recurrence of withdrawal symptoms.*

*Pregnancy is associated with increased access to healthcare, and increased motivation for recovery, presenting an opportunity to engage patients in treatment. Stigma and lack of knowledge regarding treatment options for these women creates barriers to appropriate treatment.<sup>64</sup> Pregnancy is not usually an optimal time to taper or reduce dosing unless circumstances require it.*

*Breast-feeding should be encouraged unless contraindicated by HIV.*

### **Confidentiality**

Establishing a trusting and collaborative relationship with the patient is paramount. Patients should be assured of the confidentiality of the information they disclose, clinicians should emphasize that there is no legal obligation to report substance use and risks to the fetus during pregnancy.<sup>65</sup> This is a key point in the initial discussion as, according to numerous studies, the fear of intervention by child welfare services and losing custody of a child is a major barrier to seeking treatment for pregnant women who use substances.<sup>66</sup>

### **OAT treatment**

**Compared to untreated opioid use disorder and medically managed withdrawal, treatment is associated with improved neonatal outcomes** (e.g. longer gestation, higher live birth rates, higher birth weights, and earlier discharge of infants from hospital).<sup>67</sup> There is considerable evidence for the effectiveness and safety of methadone prescribed in OAT during pregnancy; however, there is growing evidence in support of the buprenorphine and buprenorphine/naloxone use during pregnancy.

#### ***Methadone:***

Methadone dosing principles for pregnant individuals do not differ from the general adult population, but for some pregnant patients on methadone, the acceleration of maternal metabolism during pregnancy may require an increase in daily dose, particularly in the second or third trimester. If needed, gradual dose increases can be made by increments

of 5 mg to 10 mg. Due to increased hepatic metabolism of methadone in pregnancy, split dosing may be considered to prevent withdrawal symptoms.

***Buprenorphine/naloxone:***

There is theoretical risk that naloxone may pose to the fetus via elevating maternofetal cortisol levels, but emerging evidence has prompted the removal of pregnancy as a contraindication for buprenorphine/naloxone.<sup>68</sup> Initiation of buprenorphine/naloxone should be considered on a case-by-case basis. In cases in which the patient has achieved clinical stability on buprenorphine/naloxone prior to pregnancy, continuation of treatment is recommended. Transition to buprenorphine monotherapy during pregnancy is not necessary but may also be offered to a patient. Neonatal opioid withdrawal syndrome (NOWS) resulting from buprenorphine may be less severe due to its partial agonist characteristics. Additionally, due to its superior safety profile, buprenorphine may be advantageous compared to other OAT in rural areas where access to specialised care is limited.<sup>69</sup>

***Buprenorphine:***

Buprenorphine available as a single agent sublingual tablet without naloxone, is not readily available in Canada, but can possibly be accessed via a [special access program](#).

**Tapering**<sup>70</sup>

Tapering and/or detox during pregnancy will prevent complications of acute withdrawal (e.g. premature labour, spontaneous abortion). Tapering will also minimize or prevent NOWS. Although there are benefits, it is a risky option for patients because relapse rates and associated harms are very high. It is important to note that a taper and the period of abstinence puts the woman at risk for overdose if she relapses. Naloxone is contraindicated in pregnancy for an opioid overdose, as it would cause acute withdrawal, placing the fetus at risk. The success rate of opioid abstinence 18 months post-taper is only 13%. This could lead to patients being unlikely to attend obstetrician appointments and increases the likelihood of RUDS result containing either illicit substances, prescription medications not prescribed to the patient, or an absence of the OAT medication. Withdrawal management or detox treatment is not recommended in pregnancy because of the potential harms to the mother and fetus, as well as the increased infectious disease risk.

It is suggested that OAT be continued throughout the pregnancy and at least 6 months post-delivery. This allows for mother-baby attachment, which is viewed favourably by child-protection agencies. It also helps the mother get through the stress of pregnancy and looking after a small infant and the possible risk factors for relapse such as: decreased sleep, increase in mood changes, change in relationships, and isolation.

### **Intrapartum considerations:**<sup>71</sup>

OAT should be continued through labour and considered separate from any pain management strategies employed during labour and delivery. If liquids are contraindicated during labour (e.g., if the risk of needing anaesthesia is high) parenteral opioids (e.g., injectable hydromorphone) may replace methadone. Regular pain management for labour and delivery may be provided alongside OAT. While epidural anaesthesia is often the preferred pain management analgesic method for this population, the full range of pain management options (including non-pharmacological and non-analgesic options) may be considered to accommodate each patient's circumstances and preferences. If opioid analgesics are used for labour pain management, higher doses may be required to compensate for increased tolerance, and the patient must be monitored for respiratory depression and somnolence. It should be noted that opioid-dependent patients may be hyperalgesic and may require a multimodal approach to pain treatment involving additional pain treatment medications. Good communication between the clinical care team and patient is essential throughout pregnancy to devise an appropriate pain management strategy. For patients with a history of sexual trauma and post-traumatic stress disorder, labour may trigger symptoms that, in turn, intensify labour pain. Informed consent prior to every exam, particularly vaginal exam, should be sought as an essential aspect of patient-centred and trauma-informed care.<sup>72</sup>

### **Neonatal opioid withdrawal syndrome (NOWS) - also referred to as Neonatal abstinence syndrome (NAS)**

Neonatal opioid withdrawal syndrome (NOWS) refers to the constellation of possible postnatal symptoms experienced by new-borns whose mothers used opioids during pregnancy. NOWS is highly variable in its clinical manifestations, and it is important to note that it is a treatable syndrome and should not be viewed as addiction in infants. Infants with known in utero opioid exposure should undergo inpatient monitoring for a minimum of 72 hours as the onset of NOWS depends on half-life of opioid used by mother. Finnegan's score is typically used to assess NOWS, but that measure suffers from intra-observer error and could potentially disrupt the infants sleep and feeding cycle. For these reasons, a more simplified and objective assessment method focused on weight gain and ability to sleep should be used. **A dogmatic adherence to a Finnegan's score is to be avoided.** See the Assessment for Neonatal Opioid Withdrawal on the following page.

*More information regarding the management of infants born to mothers who have used opioids during pregnancy can be found here via [the Canadian Paediatric Society](#).*

## **Assessment for Neonatal Opioid Withdrawal**<sup>73</sup>

*To minimize intra-observer error and disruption to the infant's sleep and feeding cycles, Finnegan's scoring is discarded for a simplified and more objective assessment method focused on two major factors: 1) adequacy of **weight gain** and 2) **ability to sleep and be consoled**.*

### **1. Weight Gain**

- Babies should be weighed daily.
- Up to 10% weight loss within the first 72 hours (e.g. the length of time it generally takes for routine feeding patterns to get established) is acceptable and does not require initiation of morphine. In this case, clinicians should identify and address the potential causes of weight loss in communication and collaboration with the mother.
  - Insufficient breast milk or the infant's tendency to fall asleep during breastfeeding are common causes of inadequate weight gain in new-borns and can be addressed by supplementing breastfeeding with formula or donated breast milk. Supplementary bottle feeding may help avoid treatment with morphine.
  - Causes other than neonatal opioid withdrawal for diarrhea and vomiting should be considered and addressed.
- Morphine initiation or increase may be considered if adequate weight gain is not established despite these measures after the first 72 hours.

### **2. Ability to cope and be consoled**

- Rooming-in and continuous skin-to-skin contact with the mother has been shown to significantly ameliorate neonatal distress, eliminating or considerably decreasing the need for morphine treatment. These non-pharmacological measures should be taken to address high pitched crying and inability to sleep prior to considering morphine.
- Morphine may be considered if the infant cannot be consoled, and high-pitched crying does not subside within 10 minutes or sleep undisturbed for at least 1 hour.

### **Rooming-in and Breastfeeding**<sup>74</sup>

*Keeping mothers and infants together following delivery (i.e., rooming-in) is associated with healthy mother-infant bonding leading to improved long-term developmental outcomes, higher likelihood of breastfeeding, improved access to integrated care and initial childcare education in*

*a family-centred setting, reduced need for pharmacological treatment for NOWS, and fewer neonates discharged to foster care. Breastfeeding should be encouraged in mothers who are stable on OAT, the benefits of breastfeeding outweigh the potential harms.<sup>75</sup> The methadone found in breast milk may help treat NOWS. Buprenorphine is poorly bioavailable and only low levels appear in breast milk, so it also considered safe.*

## Standards

1. The prescriber must offer OAT to patients who are pregnant and opioid-dependent on a priority basis.
2. The prescriber will refer, if required, pregnant OATP patients for obstetrical care as soon as pregnancy is confirmed.
3. All prescribers caring for an OAT patient must communicate and collaborate with the obstetrical physician and hospital staff regarding the use of OAT during pregnancy, the plan for labour and delivery, and remain available for consultation and assistance as required.

## Guidelines

1. Opioid-dependent patients who become pregnant shall be encouraged to continue OATP during their pregnancy.
2. Plans should be made well in advance for continuation of OATP during in-hospital perinatal care.
3. The Prescriber may need more frequent contact (face-to-face visits or telephone contact) with the patient during the immediate postpartum period.
4. Unless clinically indicated transitioning between methadone, buprenorphine/naloxone during pregnancy and postpartum periods is not recommended for patients who are stable on one of these medications prior to becoming pregnant.<sup>76</sup>
5. Prescribers should encourage breastfeeding for mothers on OAT (unless otherwise contraindicated).
6. Prescribers should consider changing the dosage of OAT during pregnancy.
  - a. Methadone may need a dose increase in the third trimester for patients who experience early withdrawal due to changes in the metabolism of methadone.
  - b. Buprenorphine may need a dose increase in the first and second trimester. Buprenorphine treatment might also require lower dosing in the third trimester due to changes in plasma volume, tissue binding, blood flow, and changes in metabolism.

7. An OAT will not provide adequate pain relief during labour and additional analgesia should be considered. Regular OAT dosage should be continued and not considered as part of the pain management plan.
8. *\*For methadone patients only\** Postpartum maternal methadone requirements usually drop. The dose may need to be decreased by 5 to 10 mg weekly until a new stable dose is reached. Following the reduction in dose, split doses may no longer be required.

## 21. Special Situations: Concurrent Diseases<sup>77</sup>

*Patients receiving OAT frequently have other medical conditions, including psychiatric diagnoses, for which they receive medication. People with a history of addiction to one substance have a much greater risk of developing other addictions. Information and communication between all healthcare providers is essential for patient safety and wellbeing. Patients with OUD should be screened for comorbid diseases, as prevalence is high. A specific treatment plan must be documented for each specific condition. Be aware that both opioid agonist options suppress respiration and can interact with many medications. Every patient in an OATP should receive a thorough evaluation of all medications and on an ongoing basis.*

### **Infectious disease:**

Illicit drug use, street involvement, and needle sharing puts patients at greater risk of infectious disease like Hepatitis C and HIV. As such, individuals who exhibit risky behaviours should be tested for these conditions along with Hepatitis A and B, tuberculosis, and syphilis. Periodic retesting when a patient is part of an OATP should occur as risky behaviours resurface. Patients with opioid use disorder are better retained on HIV treatment regimens if they receive OAT treatment.<sup>78</sup> Based on this information, and the associated public health costs of untreated HIV, these patients should receive priority access into OATPs.

Patients being managed for Hepatitis C and HIV should be educated on the benefits of harm reduction, specifically the use of condoms and needle exchange programs. Additionally, immunizations should be addressed, and these patients should receive vaccinations for Hepatitis A and B, as well as any other relevant outstanding vaccinations. Treatment of these patients should be referred to the expertise of a physician with an expertise in the area. Co-administration of Hepatitis and/or HIV/AIDS treatment along with OAT in daily witness dosing should be considered to improve adherence to medication. However, prescribers should be aware that medications used in the treatment of these infectious diseases have the potential to interact with OAT (See **Appendix F**). These interactions must be managed and may require a change in dose of the OAT. Specific information regarding this can be acquired from a pharmacist.

### **Useful resources:**

#### **Provincial government resource on HIV testing, treatment, and support**

<https://www.saskatchewan.ca/residents/health/diseases-and-conditions/human-immunodeficiency-virus-hiv>

#### **Saskatchewan HIV resources for healthcare professionals**

<https://skhiv.ca/resources-for-healthcare-professionals/>

#### **Saskatchewan HIV community organizations**

<https://skhiv.ca/community-based-organizations/>

#### **PREP algorithm**

<https://skhiv.ca/wp-content/uploads/2018/03/Pre-Exposure-Prophylaxis-Algorithm-for-Use.pdf>

#### **Resource on HIV and injectable drug users**

<https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/people-inject-drugs>

### **Mental health:**

Prevalence of co-occurring mental health disorders in substance dependent patients is common, and often contributes to continued substance use. Initial assessment of patients for OUD should always include screening questions for comorbid mental illnesses. Screening should include family history, drug abstinence periods and past treatments. In co-occurring mental health disorders, there is an increased risk of suicide, chronic illness, homelessness, and social withdrawal.<sup>79</sup>

It may be difficult to determine whether a psychiatric disorder is primary or secondary to substance use disorder.<sup>80</sup> Opioid withdrawal often presents as increased anxiety, mood instability and in some cases can trigger underlying psychosis.<sup>81</sup> These symptoms tend to subside over a period of approximately four weeks, during which careful monitoring and risk assessment is needed. The distinction may be clearer, as in the case of a rapidly resolving psychotic state, on cessation of cocaine or crystal methamphetamine use.<sup>82</sup> In order to differentiate primary from secondary psychiatric disorders, a skilled assessment is required that takes into account symptom progression during substance use and periods of abstinence.<sup>83</sup> Referral to a specialist should be considered as needed.

### **Useful resources:**

#### **Canadian Best Practice guidelines of Concurrent Mental Health and Substance Use Disorders**

<http://publications.gc.ca/collections/Collection/H39-599-2001-2E.pdf>

#### **Canadian mental health association (Saskatchewan division)**

<https://sk.cmha.ca/types-programs-services/programs/>

#### **Mental health directory**

<http://publications.gov.sk.ca/documents/13/106350-MHA-Services-Directory-Saskatchewan-2018.pdf>

### **Polysubstance use:**<sup>84</sup>

Benefits of OATP are reduced if there is continued psychoactive substance use. Polysubstance use of both prescription and illicit drugs is common among OUD patients.<sup>85</sup> All patients require a comprehensive assessment that includes a detailed inventory of drug use and an individualized treatment plan.

#### *Alcohol*

- Risk of overdose is increased due to synergistic respiratory depressant effects between alcohol and OAT
- Alcohol also influences metabolism of both drugs
  - The early stages of problem drinking can induce hepatic enzymes and accelerate OAT metabolism
  - At later stages liver failure can reduce tolerance to OAT
- Screening and monitoring of alcohol use are important for OAT

### *Sedative-hypnotics (benzodiazepines, and Z-drugs)*

- Like alcohol, sedative-hypnotics have synergistic respiratory depressant effects when used with OAT that increase the risk of fatal overdose.
- The recommendation is to avoid the combined use of sedatives with OAT. If co-prescribed, there should be clear benefit and a well-documented rationale.

### *Marijuana*

- Its use could undermine treatment focused on developing non-chemical coping strategies.
- There is evidence that psychosis, anxiety, mood disorders, and permanent cognitive changes can occur secondary to chronic use.

### *Tobacco*

- There is a high usage of tobacco in people with OUD.
- Tobacco-related morbidity and mortality are significant.
- Physicians should ask about tobacco use and advise users to quit.

### *Stimulants*

- OUD patients can have concurrent stimulant use disorder.
- Unrecognized stimulant use could undermine OAT.

## Standards

1. The prescriber must assess the patient for comorbid infectious disease (e.g. HIV, Hepatitis C), mental health, and polysubstance use before initiating OAT, or as soon as possible thereafter.
2. OATP patients must be re-evaluated for co-morbid infectious disease, mental health, and polysubstance use annually or more often as clinically required.

## 22. Special Situations: Rural and Remote Treatment<sup>86</sup>

There are common barriers that limit access to addiction services in Saskatchewan, especially in rural and remote areas. Barriers include the costs associated with travel, lack of transportation, social stigma, discrimination, and the availability of support services (such as alcoholics anonymous, narcotics anonymous, and counselling). Coupled with the urban-centric distribution of treatment facilities, prescribers may feel pressure to take on more OATP patients than they can integrate into their practice.

Geographical factors may make it difficult for patients to attend regularly for face-to-face visits with their prescriber. As well, daily witness ingestion and RUDSs may be problematic for patients, especially when they live a great distance from their health care providers.

Buprenorphine/naloxone taken every other day, or less than daily dosing, may be a useful tool, as well as carries of OAT (see *Section 14: Carries*).

It may be difficult for some patients with OUD to access all the supports or programs available if they reside in a rural location. It is important that a patient is aware of what is available to him/her, and how to access it.

### **Directory of mental health and addictions services in Saskatchewan**

<http://publications.gov.sk.ca/documents/13/106350-MHA-Services-Directory-Saskatchewan-2018.pdf>

### **Take home naloxone provider link**

<https://www.skpharmacists.ca/site/res/Opioid%20Use%20Disorder>

### **Patients also have access to the 811 Health-line if needed, addiction support and counselling are within the purview of this service**

<https://www.saskatchewan.ca/residents/health/accessing-health-care-services/healthline>

### 23. Special Situations: Acute and Chronic Pain Considerations

OAT prescribers are often in an optimal position to manage acute (including post-partum) and chronic pain. Patients should be supported in finding alternative pain treatment (including non-opioid pharmacotherapy and non-pharmacological therapy) that are financially and geographically accessible and culturally appropriate.

#### Standards

1. Explore non-pharmacological therapies that align with the patient's goals and values.
2. Consider non-opioid analgesic options before opioid options.
3. Avoid high-risk, mixed CNS depressant combinations when possible (e.g. opioids with gabapentin/pregabalin).
4. If there are concerns with stability and/or diversion, prescribe a dispensing schedule that involves controlled dispensing (preferably daily) for all high-risk medications and limit the prescription to the number of days typically needed for the specific acute pain condition.

#### Guidelines

1. Avoid the patient's previously reported opioid of choice if prescribing opioids.

##### *Acute Pain*

2. Consider opioids in addition to Bup/Nx for patients with acute pain that warrants short-term opioid therapy and/or temporarily split the OAT dose and assess the need for a temporary increase OAT dose. The dose of additional full agonist opioid analgesic prescribed, in supervised settings (e.g. during hospitalization), is anticipated to be higher than the typical dose necessary to achieve adequate analgesia in patients who are opioid-naïve.<sup>87</sup>

##### *Chronic Pain*

3. Consider prescribing split doses for patients with chronic pain. Usually this occurs after the patient reaches a stable, once-daily dose and becomes eligible for take-home doses. Only provide take-home doses when the patient is clinically stable.
4. Where available, formally, or informally consult with a pain expert to enhance the patient's treatment plan if chronic pain persists after stabilization and optimization of OAT doses.

## 24. Considerations for Surgery<sup>88</sup>

Discontinuation of buprenorphine or methadone prior to surgery is not required. Higher potency intravenous full agonist opioids (e.g. hydromorphone) can be used perioperatively for analgesia in addition to the patient's regular dose of buprenorphine or methadone (except to the extent that doses may be skipped during the NPO period before surgery).

Since buprenorphine has a high affinity for the mu-opioid receptor, there were initially concerns that full-opioid agonists would not be effective; however, research has demonstrated that the addition of full opioid agonists can be effective for the treatment of pain in these patients. Reducing the dose of buprenorphine to provide more mu-opioid receptor availability and increase the efficacy of full opioid agonists co-administered with buprenorphine has been suggested but there is insufficient research on this topic. Decisions to change the dose prior to a planned surgery should be made on an individual basis, in consultation with the patient's OAT provider.

## 25. Harm Reduction

Harm reduction refers to a range of policies, programs, or services that are designed to reduce the social, physical, and economical consequences of licit and illicit substance abuse. In Saskatchewan we have provincially funded Prevention and Risk Reduction (PRR) programs.<sup>89</sup> All patients with OUD should have same-day access to harm reduction services. PRR programs provide supplies and services to reduce the risks associated with injection drug use. The range of services look to enhance the knowledge, skills, resources, and supports for individuals engaging in high-risk behaviour.<sup>90</sup> Saskatchewan continues to lead the country in rates of new cases of HIV and Hepatitis C, a major risk factor for these infectious diseases is injection drug use. PRR programs provide equipment and supplies for those who inject drugs to reduce spread of diseases. The distribution of supplies reduces the sharing of used needles/ syringes and other injecting equipment. PRR programs are also a means of connecting with clients and engaging them in care.

What services are provided by Prevention and Risk Reduction (PRR) programs? <sup>91</sup>	
Supplies	Needles & syringes are provided by every PRR program. Clients return used needles and receive a similar quantity of new ones. Emergency packs are available without a return. As part of biohazard waste management, locations that offer needles also have community drop boxes for year-round needle return.
Other Items	Sterile water, tourniquets, spoons/ cookers, alcohol swabs, dental pellets, condoms, lubricant, and sharps containers. Some provide basic first aid supplies, travel kits for their supplies, hygiene items, transportation voucher, clothing, and food.
Programs	Programs organize a variety of activities, such as spring clean ups, for picking up needles discarded in the community.
Services	Many provide health care, education, counselling, and support services including information on nutrition; testing for HIV, Hepatitis B, Hepatitis C, and sexually transmitted infections and referral for treatment; counselling regarding social issues (housing, abuse, addictions, mental health, etc.) general health issues, sexual health, pregnancy, and birth control; immunizations, and first aid, abscess and vein care.  Some programs offer snacks, transportation, vitamin supplements, and other emergency services on a drop-in basis.
Referrals	Programs are primarily staffed by Public Health Nurses (PHNs), social workers, or addictions counsellors trained to assist clients with a broad range of medical and social issues. Referrals are offered to other agencies, including those providing medical, dental, social, sexual assault, and addiction services, including methadone maintenance treatment and recovery. Referrals are made to off-site mental health or social service agencies when the program either does not provide the service or if an assessment warrants the intervention of a specialized counsellor or health care professional.

Care service provided by PRR <sup>92</sup>							
Former Sask Health Regions	Regina Qu'Appelle	Saskatoon	Prince Albert Parkland	North	Sunrise	Prairie North	5 Hills
Risk Reduction Counselling	✓	✓	✓	✓	✓	✓	✓
Vein Maintenance	✓	✓	✓		✓	✓	✓
Addictions counselling	✓	✓	✓	✓	✓	✓	
Hepatitis A/B Immunization	✓	✓	✓	✓	✓	✓	✓
HIV, Hepatitis B, Hepatitis C counselling/ care	✓	✓	✓	✓	✓	✓	✓
Abscess counselling/ care	✓		✓	✓	✓	✓	
STI counselling/ Care	✓	✓	✓	✓	✓	✓	✓
Abuse counselling	✓	✓	✓			✓	
Mental health issues counselling	✓	✓			✓	✓	
Pregnancy counselling	✓	✓	✓		✓	✓	✓
Birth Control Counselling	✓	✓	✓		✓	✓	✓

The locations of these PRR harm reduction sites are shown in the table below. Along with a helpful map. It is important to know that two sites located in Saskatoon and Regina are mobile sites run from a van, so their exact location may vary.

PRR locations	
Former RHAs	Site location
Regina Qu'Appelle	Public Health (downtown) + Mobile Van
	Carmichael Outreach
	AIDS programs South Saskatchewan
Saskatoon	Saskatoon Sexual Health Clinic + mobile Van
	AIDS Saskatoon
Prince Albert Parkland	Access Place – Sexual Health Clinic
Five Hills	Moose Jaw Public Health
Prairie North	Battlefords Sexual Health Clinic
	North Battleford Public Health
	Meadow Lake Public Health (downtown)
	Meadow Lake Public Health
	Meadow Lake Hospital ER
	Door of Hope Clinic, Meadow Lake (once per week)
	Meadow Lake Primary Health Care Centre (once per week)
	Lloydminster Native Friendship Centre (twice per week)
Mamawetan	La Ronge Health Centre
	Scattered Site Outreach
Keewatin Yatte	La Loche Health Centre
	Buffalo Narrows Health Centre
	Ile a la Crosse Public Health
	Green Lake Health Centre
	Beauval Health Centre
Sunrise	Yorkton Public Health (SIGN building)
	Kamsack Hospital



In addition to PRR and needle change another important harm reduction measure is naloxone kits provision and availability. Anyone who might be at risk of an overdose because of prescription medication use, illicit or licit drug abuse should receive education and access to a naloxone kit. If they cannot be given a kit directly a prescription for one and information as to where to fill the prescription would suffice.

Take home naloxone provider link:

<https://www.skpharmacists.ca/site/res/Opioid%20Use%20Disorder>

Another important piece of harm reduction for addictions patients who may display more risky behaviours, or street involved would be access to regular STI testing, and condoms. Saskatchewan prevention institute has developed an app titled Keep It Safe Saskatchewan (KIP-SK) which has information regarding contraceptives, STIs, videos, and a reminder calendar for oral contraceptives. The KIP-SK app also has an interactive map feature which displays everywhere in Saskatchewan someone can access free STI testing, both walk-in and by appointment. The app also showcases where in Saskatchewan someone can get access to free condoms.

Link to App webpage:

<http://skprevention.ca/kis-sk/#toggle-id-10-closed>

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## Appendices

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### Appendix A: Motivational Strategies for Each Stage of Change

Below is a copy of the *APPROPRIATE MOTIVATIONAL STRATEGIES FOR EACH STAGE OF CHANGE* document from U.S. Department of Health and Human Services. Center for Substance Abuse Treatment. Miller WR, Consensus Panel Chair. Enhancing motivation for change in substance abuse treatment. Rockville (MD): the Center, 1999. (Treatment improvement protocol (TIP) series; 35). <http://www.ncbi.nlm.nih.gov/books/NBK64967/>.

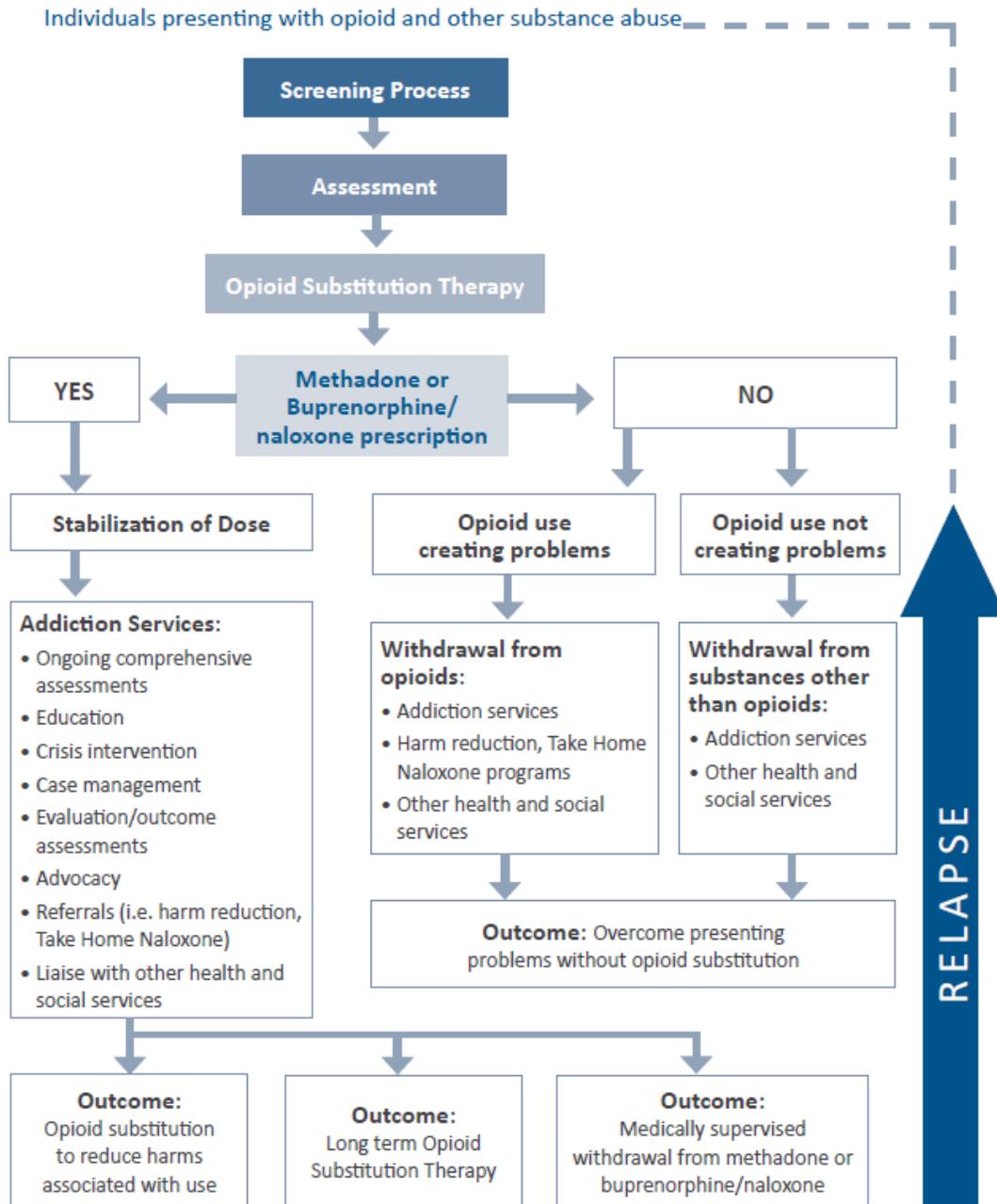
<b>Motivational Strategies for Each Stage of Change</b>	
<b>Patient's Stage of Change</b>	<b>Appropriate Motivational Strategies for the Clinician</b>
<p><b><u>Pre-contemplation</u></b></p> <p>The patient is not yet considering change or is unwilling or unable to change</p>	<ul style="list-style-type: none"><li>- Establish a rapport, ask permission, and build trust</li><li>- Express concern and keep the door open</li><li>- Raise doubts or concerns in the client about substance-using patterns by:<ul style="list-style-type: none"><li>o Exploring the meaning of events that brought the client to treatment or the results of previous treatments</li><li>o Eliciting the patient's perceptions of the problem</li><li>o Offering information about the risks of substance use</li><li>o Providing personalized feedback about assessment findings</li><li>o Exploring the pros and cons of substance use</li><li>o helping a significant other intervene</li><li>o examine discrepancies between the clients and other perceptions of the problem behavior</li></ul></li></ul>

Patient's Stage of Change	Appropriate Motivational Strategies for the Clinician
<p><b><u>Contemplation</u></b></p> <p>The patient acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain</p>	<ul style="list-style-type: none"> <li>- Normalize ambivalence</li> <li>- Help the patient towards change by: <ul style="list-style-type: none"> <li>o eliciting and weight pros and cons of substance use and change</li> <li>o changing extrinsic to intrinsic motivation</li> <li>o examine the client's personal values in relation to change</li> <li>o emphasizing the client's free choice, responsibility and, self-efficacy for change</li> </ul> </li> <li>- Elicit self-motivational statements of intent and commitment from the patient</li> <li>- Elicit ideas regarding the clients perceived self-efficacy and expectations regarding treatment</li> <li>- Summarize self-motivational statements</li> </ul>
<p><b><u>Preparation</u></b></p> <p>The patient is committed to and planning to make a change soon but is still considering what to do.</p>	<ul style="list-style-type: none"> <li>- Clarify the patient's own goals and strategies for change</li> <li>- Offer a menu of options for change or treatment</li> <li>- With permission offer expertise and advice</li> <li>- Negotiate a change- or treatment- plan and behavior contract</li> <li>- Consider and lower barriers to change</li> <li>- Help the patient enlist in social support</li> <li>- Explore treatment expectancies and the patient's role</li> <li>- Elicit from the patient what has worked in the past either for him or others whom her/she knows</li> <li>- Assist the patient to negotiate finances, childcare, work, transportation, or other potential barriers</li> <li>- Have the patient publicly announce plans to change</li> </ul>
<p><b><u>Action</u></b></p> <p>The patient is actively taking steps to change but has not yet reached a stable state</p>	<ul style="list-style-type: none"> <li>- Engage the patient in treatment and reinforce the importance of remaining in recovery</li> <li>- Support a realistic view of change through small steps</li> <li>- Acknowledge difficulties for the patient in early stages of change</li> <li>- Help the patient identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these</li> <li>- Assist the client in finding new reinforcers of a positive change</li> <li>- Help the patient assess whether her/she has strong family and social support.</li> </ul>

Patient's Stage of Change	Appropriate Motivational Strategies for the Clinician
<p><b><u>Maintenance</u></b></p> <p>The patient has achieved initial goals such as abstinence and is now working to maintain goals</p>	<ul style="list-style-type: none"> <li>- Help the client identify and sample drug-free sources of pleasure (e.g. new reinforcers)</li> <li>- support lifestyle changes</li> <li>- Affirm the clients resolve and self-efficacy</li> <li>- Help the patient practice and use new coping strategies to avoid return to use</li> <li>- Maintain supportive contact (e.g. explain to patient that you hare available to talk between sessions)</li> <li>- Develop a plan if the patient resumes substance use</li> <li>- Review long-term goals with the client</li> </ul>
<p><b><u>Recurrence</u></b></p> <p>The patient has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next</p>	<ul style="list-style-type: none"> <li>- Help the patient reenter the change cycle and commend any willingness to reconsider positive change</li> <li>- Explore the meaning and reality of the recurrences as a learning opportunity</li> <li>- Assist the client in finding alternative coping strategies</li> <li>- Maintain supportive contract</li> </ul>

## Appendix B: Overview of OAT<sup>1</sup>

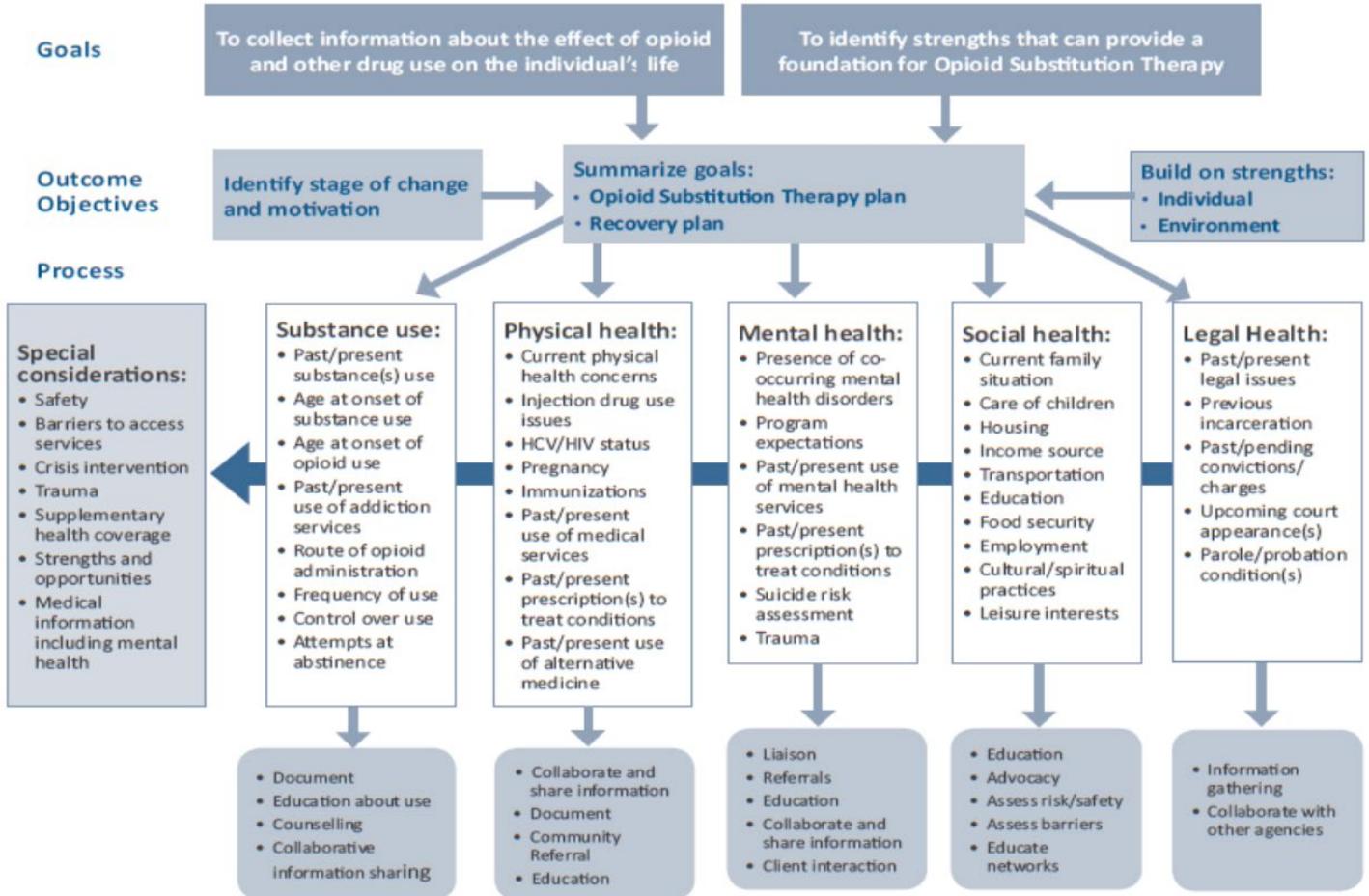
### OPIOID SUBSTITUTION THERAPY OVERVIEW



<sup>1</sup> Government of Saskatchewan. (2018). *Opioid Substitution Therapy: Guidelines for Saskatchewan Addiction Counsellors*. (p. 9) Retrieved from <http://publications.gov.sk.ca/documents/13/106993-OST-Guidelines-June-5.pdf>

## Appendix C: Addictions Counsellor Assessment<sup>2</sup>

### COMPREHENSIVE ASSESSMENT



<sup>2</sup> Government of Saskatchewan. (2018). Opioid Substitution Therapy: Guidelines for Saskatchewan Addiction Counsellors. (p. 14) Retrieved from <http://publications.gov.sk.ca/documents/13/106993-OST-Guidelines-June-5.pdf>

## Appendix D: Prescribing of Methadone and/or Buprenorphine for Opioid Use Disorder – Policies



## POLICY

### Opioid Agonist Therapy (OAT) Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018 March 2019
<b>Amended:</b>	June 2022
<b>To be reviewed:</b>	June 2027

#### 1. OAT Prescribing for MAINTAINING (Non-Initiating) Physicians for OPIOID USE DISORDER

Physicians authorized to prescribe **BOTH methadone and buprenorphine/naloxone** in the management of opioid use disorder in stable patients are:

1. Required to understand methadone and buprenorphine/naloxone pharmacology and have completed an OAT workshop/course recognized by the CPSS.
2. Required to agree to follow the Policies or Standards of the CPSS related to the prescribing of methadone or buprenorphine/naloxone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of methadone and buprenorphine/naloxone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to agree to participate in an audit of their prescribing of methadone or buprenorphine/naloxone if requested by the CPSS Registrar.
5. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
6. Required to have an ongoing association with an experienced Initiating Prescriber who serves as a resource to the Maintaining Prescriber.
7. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe methadone or buprenorphine/naloxone.
8. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe methadone or buprenorphine/naloxone.
9. Required to have access to counseling and pharmacy services.

10. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
11. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
12. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become an opioid agonist therapy prescriber for the purpose of treating opioid use disorder in stable patients. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_



## POLICY

### Methadone Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018
<b>Amended:</b>	March 2019
	June 2022
<b>To be reviewed:</b>	June 2027

### 2. Methadone Prescribing for MAINTAINING (Non-Initiating) Physicians for OPIOID USE DISORDER

Physicians authorized to prescribe **ONLY methadone** in the management of opioid use disorder in stable patients are:

1. Required to understand methadone pharmacology and have completed an OAT workshop/course recognized by the CPSS.
2. Required to agree to follow the Policies or Standard of the CPSS related to the prescribing of methadone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of methadone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to agree to participate in an audit of their prescribing of methadone if requested by the CPSS Registrar.
5. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
6. Required to have an ongoing association with an experienced Initiating Prescriber who serves as a resource to the Maintaining Prescriber.
7. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe methadone.
8. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe methadone.

9. Required to have access to counseling and pharmacy services.
10. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
11. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
12. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become a methadone prescriber for the purpose of treating opioid use disorder in stable patients. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_



## POLICY

### Buprenorphine/naloxone Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018
<b>Amended:</b>	March 2019 June 2022 November 2022
<b>To be reviewed:</b>	June 2027

### 3. Buprenorphine/naloxone Prescribing for MAINTAINING (Non-Initiating) Physicians for OPIOID USE DISORDER

Nothing in this policy applies to a physician who:

- provides buprenorphine/naloxone treatment in an Emergency Department following a protocol established by the Saskatchewan Health Authority or the hospital in which it is prescribed; or,
- provides buprenorphine/naloxone treatment in hospital to maintain a patient who is receiving buprenorphine/naloxone treatment prior to their hospitalization; or,
- provides buprenorphine/naloxone treatment in a correctional facility to maintain a patient who is receiving buprenorphine/naloxone treatment prior to their incarceration.

Physicians who provide buprenorphine/naloxone treatment in such circumstances should be aware of and follow the College's document *Opioid Agonist Therapy Program Standards and Guidelines for the Treatment of Opioid Use Disorder*.

Physicians authorized to prescribe **ONLY buprenorphine/naloxone** in the management of opioid use disorder in stable patients are:

1. Required to understand buprenorphine/naloxone pharmacology. Completion of an OAT workshop/course recognized by the CPSS is strongly recommended.
2. Required to agree to follow the Policies or Standard of the CPSS related to the prescribing of buprenorphine/naloxone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of buprenorphine/naloxone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to agree to participate in an audit of their prescribing of buprenorphine/naloxone if requested by the CPSS Registrar.

5. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
6. Required to have an ongoing association with an experienced Initiating Prescriber who serves as a resource to the Maintaining Prescriber.
7. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe buprenorphine/naloxone.
8. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe buprenorphine/naloxone.
9. Required to have access to counseling and pharmacy services.
10. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
11. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
12. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become a buprenorphine/naloxone prescriber for the purpose of treating opioid use disorder in stable patients. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_



## POLICY

### Opioid Agonist Therapy (OAT) Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018
<b>Amended:</b>	March 2019 June 2022
<b>To be reviewed:</b>	June 2027

#### 4. OAT Prescribing for INITIATING Physicians for OPIOID USE DISORDER

Physicians authorized to prescribe **BOTH methadone and buprenorphine/naloxone** in the management of opioid use disorder are:

1. Required to have the following training and experience:
  - a. Completion of a methadone and buprenorphine/naloxone workshop or course recognized by the CPSS;
  - b. A period of direct training (or equivalence, as authorized by the CPSS), supervision and mentorship with an experienced, CPSS-approved Initiating Prescriber;
  - c. Documentation of clinical competence from a mentoring prescriber;
  - d. CPSS approved mentorship and support from an established methadone prescriber during the first two years of practice.
2. Required to agree to follow the Policies or Standard of the CPSS related to the prescribing of methadone or buprenorphine/naloxone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of methadone and buprenorphine/naloxone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to pursue ongoing education relevant to OAT prescribing.
5. Required to alert the CPSS when they have taken on and treated 25 patients using methadone for opioid use disorder if they are a new methadone prescriber.
6. Required to agree to participate in an audit of their prescribing of methadone or buprenorphine/naloxone if requested by the CPSS Registrar.
7. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
8. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe methadone or buprenorphine/naloxone.

9. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe methadone or buprenorphine/naloxone.
10. Required to have access to one or more addiction counselors and one or more pharmacists to provide patients the full range of treatment options.
11. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
12. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
13. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in *the CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become an opioid agonist therapy prescriber for the purpose of treating opioid use disorder. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_



## POLICY

### Methadone Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018
<b>Amended:</b>	March 2019
	June 2022
<b>To be reviewed:</b>	June 2027

### 5. Methadone Prescribing for INITIATING Physicians for OPIOID USE DISORDER

Physicians authorized to prescribe **ONLY methadone** in the management of opioid use disorder are:

1. Required to have the following training and experience:
  - a. Completion of a methadone workshop or course recognized by the CPSS;
  - b. A period of direct training (or equivalence, as authorized by the CPSS), supervision and mentorship with an experienced, CPSS-approved Initiating Prescriber;
  - c. Documentation of clinical competence from a mentoring prescriber;
  - d. CPSS approved mentorship and support from an established methadone prescriber during the first two years of practice.
2. Required to agree to follow the Policies or Standard of the CPSS related to the prescribing of methadone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of methadone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to pursue ongoing education relevant to OAT prescribing.
5. Required to alert the CPSS when they have taken on and treated 25 patients using methadone for opioid use disorder if they are a new methadone prescriber.
6. Required to agree to participate in an audit of their prescribing of methadone if requested by the CPSS Registrar.
7. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
8. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe methadone.

9. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe methadone.
10. Required to have access to one or more addiction counselors and one or more pharmacists to provide patients the full range of treatment options.
11. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
12. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
13. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in *the CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become a methadone prescriber for the purpose of treating opioid use disorder. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_



## POLICY

### Buprenorphine/naloxone Prescribing

<b>STATUS:</b>	APPROVED
<b>Approved by Council:</b>	November 2018
<b>Amended:</b>	March 2019
	June 2022
<b>To be reviewed:</b>	June 2027

#### 6. Buprenorphine/naloxone Prescribing for INITIATING Physicians for OPIOID USE DISORDER

Nothing in this policy applies to a physician who provides buprenorphine/naloxone treatment in an Emergency Department following a protocol established by the Saskatchewan Health Authority or the hospital in which it is prescribed.

Physicians authorized to prescribe **ONLY buprenorphine/naloxone** in the management of opioid use disorder in stable patients are:

1. Required to have the following training and experience:
  - a. Completion of a buprenorphine/naloxone workshop or course recognized by the CPSS;
  - b. A period of direct training (or equivalence, as authorized by the CPSS), supervision and mentorship with an experienced, CPSS-approved Initiating Prescriber;
  - c. Documentation of clinical competence from a mentoring prescriber.
2. Required to agree to follow the Policies or Standard of the CPSS related to the prescribing of buprenorphine/naloxone as they may exist from time to time.
3. Required to agree to participate in a program of continuing medical education related to the prescribing of buprenorphine/naloxone and/or addiction medicine as may be required by the CPSS Policies or Standards from time to time.
4. Required to pursue ongoing education relevant to OAT prescribing.
5. Required to agree to participate in an audit of their prescribing of buprenorphine/naloxone if requested by the CPSS Registrar.
6. Required to agree to an interview with the CPSS Registrar or their designate, if requested.
7. Required to have access to the Saskatchewan electronic Health Record (eHR) Viewer to permit monitoring of prescribed medications, as well as laboratory results for those patients to whom they prescribe buprenorphine/naloxone.

8. Required to have access to appropriate laboratory services to perform urine drug testing or to collect, store and transport urine for drug testing for those patients to whom they prescribe buprenorphine/naloxone.
9. Required to have access to one or more addiction counselors and one or more pharmacists to provide patients the full range of treatment options.
10. Required to make efforts to provide non-pharmacological support to their patients (e.g. addiction services, counseling, harm reduction, community programs, etc.)
11. Required to plan for after-hour care of their OAT patients if they are not available from another prescriber trained in OAT according to standards described in the *CPSS OATP Standards & Guidelines*.
12. Required to ensure any OAT patient under their care receives continued care from another physician trained in OAT according to standards described in *the CPSS OATP Standards & Guidelines* when they are going to be away or are suspending their practice.

I Dr. \_\_\_\_\_ have received, read and agree with the policy of Council dated \_\_\_\_\_ with respect to my request to become a buprenorphine/naloxone prescriber for the purpose of treating opioid use disorder. I will comply with this policy if I am granted approval by the Registrar of the College of Physicians and Surgeons of Saskatchewan (or approval from their designate).

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_

## Appendix E: Competency Example Letter

June 2, 2018

CPSS OATP Manager  
College of Physicians and Surgeons  
101 – 2174 Airport Drive,  
Saskatoon, SK  
S7L 6M6

### *Example 1*

Re: Dr. Smith & Opioid Agonist Therapy

Dr. Smith attended my Opioid Agonist Therapy Clinic for ½ day on May 29, 2018. She was actively engaged and very knowledgeable about Addiction Medicine and OAT. We discussed the current Standards and Guidelines; dosing of methadone and Suboxone, with an emphasis on induction; monitoring function and progress in recovery; the requirements for carries; the importance of patient engagement; and the role of psychosocial support.

It is my position that Dr. Smith is a superior candidate. I understand she had 6 months of Addiction Medicine training, in addition to a one year fellowship.

I have no hesitation to recommend her as a provider of OAT.

Sincerely,

Dr. Brown

### *Example 2*

Re: Methadone Exemption for Dr. Smith

Dr. Smith attended my Methadone clinic on May 29, 2018. I understand she has completed a methadone education program and intends to provide services in Moose Jaw at an integrated Health Authority Primary Care Site. There will be nursing and counseling support on site. Initially she would prefer to phase in her practice with established patients transferred from Regina.

She is a very competent Family Physician. She appeared knowledgeable with regard to the prescribing of methadone, interacted well with the patients, and asked many questions with regard to both safe prescribing and program logistics. She appeared committed to the development of a credible, supportive program. She has obviously given this issue serious consideration.

I would recommend Dr. Smith based upon my interactions with her, assuming all other criteria are met.

Sincerely,

Dr. Brown

## Appendix F: Drug Interactions<sup>3</sup>

This appendix outlines how methadone interacts with a variety of prescription medications.<sup>4</sup>

It is important to note that new prescription medications are introduced to the market frequently, and as a result, this is not a comprehensive list of prescription medications that interact with methadone or buprenorphine.

### **Pharmacodynamic:**

Pharmacodynamic interactions are those where the effects of one drug are changed by the presence of another drug at its site of action<sup>5</sup>. In OAT therapy, this most commonly occurs with medications that produce an additive effect along with OAT. For example:

- The combination of medications that cause sedation (e.g. alcohol, benzodiazepines) with OAT will result in high risk of toxicity, overdose, and CNS depression;
- The combination of medications that cause constipation and urinary retention (e.g. anticholinergics) will further exacerbate these undesired side effects of opioids;
- The combination of medications that cause QTc prolongations with methadone can potentially be fatal (See RxFiles table of QT prolonging agents on the following pages).

### **Pharmacokinetic:**

Pharmacokinetic interactions involve medications that interact with the metabolism of OAT and either increase or decrease OAT levels and effects. Most of these interactions involve the cytochrome P450 (CYP450) enzymes. Medications metabolized by one or more CYP enzymes are termed **substrates**.

An **inhibitor** is any medication that slows the metabolism via specific CYP enzymes resulting in a less rapid metabolism of substrate medications, which may result in higher-than-expected levels of substrate medications.

An **inducer** is any medication that boosts the activity of specific CYP enzymes resulting in more rapid metabolism of substrate medications, which may result in lower-than-expected levels of substrate medications.

Methadone is an inhibitor of CYP 2D6 and a substrate of CYP 3A4, 5, 7, and CYP 2B6.

Buprenorphine/naloxone is a substrate for CYP 3A4.

***Physicians unsure of the potential interaction between OAT and other medications must contact a pharmacist.***

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<sup>3</sup> Geri-RxFiles – 2nd Edition. QT Prolongation & Torsades de Pointes: Drugs & Sudden Death. Available from [www.RxFiles.ca](http://www.RxFiles.ca).

<sup>4</sup> College of Physicians & Surgeons and Nova Scotia, College of Registered Nurses of Nova Scotia. (2017). *Methadone Maintenance Treatment Handbook*. (p. 107) Retrieved from <https://cpsns.ns.ca/wp-content/uploads/2017/10/Methadone-Maintenance-Treatment-Handbook.pdf>

<sup>5</sup> Baxter, K., & Stockley, I. H. (2006). *Stockley's drug interactions: A source book of interactions, their mechanisms, clinical importance and management*. London: Pharmaceutical Press.

## Medications that INCREASE or DECREASE the Effect of OAT

		Increased OAT Effect	Decreased OAT Effect
<b>Anti-infection</b>	<b>Antibacterial</b>	Ciprofloxacin Clarithromycin Erythromycin	Fucidic acid
	<b>Anti-fungal</b>	Fluconazole Ketoconazole Itraconazole Posaconazole Voriconazole	
	<b>Antimalarial</b>		
	<b>Antiretroviral</b>	Delaviridine	Abacavir Amprenavir Atazanavir Boceprevir Efavirenz Etravirine Fosamprenavir Lopinavir Nelfinavir Nevirapine Rilpivirine Ritonavir Saquinavir Telaprevir Tipranavir Darunavir Delavirdine Rifampin Rifapetine Peginterferon- Alpha-2
<b>Antineoplastic</b>		Lapatinib Nilotinib Thiotepa	Dabrafenib
<b>Antihistamine</b>		Carbinoxamine Meclizine	
<b>Anti-Parkinson's</b>		Rasagiline	
<b>Cardiac</b>	<b>Ca++ channel blocker</b>	Verapamil	
<b>Corticosteroid</b>			Dexamethasone
<b>Gastrointestinal</b>	<b>Antacid</b>	Cimetidine Omeprazole	

		Increased OAT Effect	Decreased OAT Effect
<b>Neurologic</b>	<b>Anti-alcohol</b>	Disulfiram	
	<b>Anticonvulsant</b>	Perampanel	Carbamazepine Fosphenytoin Phenytoin
	<b>Migraine</b>	Dihydroergotamine	
<b>Opioids</b>			Butorphanol Fiorinal Naltrexone Nalbuphine Pentazocine Dezocine Fentanyl
<b>Progesterone receptor modulator</b>		Mifepristone	
<b>Psychiatric</b>	<b>Anti-anxiety</b>	Diazepam	
	<b>Anti-depressant</b>	Fluoxetine Fluvoxamine Moclobemide Nefazodone Paroxetine Sertraline	Desvenlafaxine Dabrafenib
	<b>Barbiturate</b>		Amobarbital Butalbital Pentobarbital Phenobarbital Secobarbital
	<b>Sedatives</b>	Fospropofol	
<b>Skeletal muscle relaxant</b>		Cyclobenzaprine	
<b>Urologic</b>	<b>Diuretic</b>		Spironolactone
	<b>Urinary acidifiers</b>		Vitamin C K-phos
	<b>Urinary alkalizers</b>	Sodium bicarbonate Potassium citrate	
<b>Herbal drugs</b>		Cats claw Chamomile Echinacea Goldenseal	St. John's wort
<b>Food</b>		Grapefruit juice	
<b>Addictive drugs</b>		Alcohol acute use	Alcohol chronic use Cocaine Heroin Tobacco

Medications That Can Prolong QT Interval

Cardiovascular	CNS / Psychotropic	Anti-Infective	Miscellaneous	Drug Interactions Cytochrome P450 Inhibitors
<p><b>Anti-arrhythmics</b></p> <p><b>Amiodarone</b> (low risk of TdP compared to other class III agents such as sotalol; however potential for DIs)</p> <p><b>Bepridil</b> <b>Bretylium</b> <b>Disopyramide</b> <b>Dofetilide</b> <b>Dronedarone</b> <b>Flecainide</b> <b>Ibutilide</b> <b>Mexiletine</b> <b>Procainamide</b> <b>Propafenone</b> <b>Quinidine</b> less at ↑ dose <b>Sotalol</b></p> <p><b>Dobutamine</b> <b>Dopamine</b> <b>Isradipine</b> <b>Moexipril/HCTZ</b> <b>Nicardipine</b> <b>Norepinephrine</b> <b>Ranolazine</b></p> <p><b>ADHD agents</b></p> <p><b>Amphetamine</b> <b>Atomoxetine</b> <b>Dexmethylphenidate</b> <b>Dextroamphetamine</b> <b>Guanfacine</b> <b>Lisdexamfetamine</b> <b>Methylphenidate</b></p> <p><b>Antiemetics</b></p> <p><b>Dolasetron</b> especially if IV <b>Domperidone</b> especially if IV, &gt;30mg orally/day, or with ketoconazole/3A4 inhibitors <b>Droperidol</b> &lt;1.25mg less QT concern <b>Granisetron</b> <b>Metoclopramide</b> <b>Ondansetron</b> especially ≥ 32mg IV, <u>not</u> over 8mg if ≥75 yrs; &gt;16mg if &lt;75yrs <b>Palonosetron</b> <b>Promethazine</b> <b>Tropisetron</b></p>	<p><b>Anticonvulsants</b></p> <p><b>Felbamate</b> <b>Lithium</b></p> <p><b>Antipsychotics</b></p> <p><b>Amisulpride</b> <b>Asenapine</b> <b>Aripiprazole</b> <b>Butyrophenones</b> <b>Haloperidol</b> esp. with ↑ dose or IV <b>Clozapine</b> <b>Phenothiazines</b></p> <ul style="list-style-type: none"> <li>Chlorpromazine</li> <li>Mesoridazine</li> <li>Perphenazine</li> <li>Thioridazine</li> </ul> <p><b>Iloperidone</b> <b>Paliperidone</b> <b>Pimozide</b> <b>Quetiapine</b> <b>Risperidone</b> <b>Thioxanthines</b> <b>Ziprasidone</b></p> <p><b>SSRIs</b></p> <p><b>Citalopram</b> if &gt;40mg/day, or elderly <b>Escitalopram</b> in high-/over-dose <b>Fluoxetine</b> <b>Paroxetine</b> especially ↑ pimoizide <b>Sertraline</b> <b>Trazodone</b></p> <p><b>SNRIs</b></p> <p><b>Desvenlafaxine</b> <b>Mirtazapine</b> <b>Venlafaxine</b></p> <p><b>TCAs</b></p> <p><b>Amitriptyline</b> Amoxapine <small>seems okay</small> <b>Clomipramine</b> <b>Desipramine</b> <b>Doxepin</b> <b>Imipramine</b> <b>Maprotiline</b> <b>Nortriptyline</b> Protriptyline <small>seems okay</small> <b>Trimipramine</b></p> <p><b>Other</b></p> <p><b>Chloral Hydrate</b> <b>Moclobemide</b></p>	<p><b>Antibiotics</b></p> <p><b>Cotrimoxazole</b> <b>Fluoroquinolones</b></p> <ul style="list-style-type: none"> <li>Ciprofloxacin –mainly if DI on a ↑ QT drug, but some direct QT effect</li> <li>Gatifloxacin</li> <li>Gemifloxacin</li> <li>Levofloxacin</li> <li>Moxifloxacin</li> <li>Norfloxacin</li> <li>Ofloxacin</li> <li>Sparfloxacin</li> </ul> <p><b>Macrolides</b></p> <ul style="list-style-type: none"> <li>Azithromycin</li> <li>Clarithromycin</li> <li>Erythromycin</li> <li>Roxithromycin</li> </ul> <p><b>Telavancin</b> <b>Telithromycin</b></p> <p><b>Azole Antifungals</b></p> <p><b>Fluconazole</b> <b>Itraconazole</b> <b>Ketoconazole</b> <b>Posaconazole</b> <b>Voriconazole</b></p> <p><b>Antimicrobials</b></p> <p><b>Artemether-lumefantrine</b> <b>Chloroquine</b> <b>Halofantrine</b> <b>Hydroxychloroquine</b> <b>Mefloquine</b> <b>Piperaquine</b> <b>Primaquine</b> <b>Quinine</b></p> <p><b>Other</b></p> <p><b>Pentamidine</b></p>	<p><b>Abiraterone acetate</b> <b>Alfuzosin</b> <b>Amantidine</b> <b>Anagrelide</b> <b>Arsenic trioxide</b> <b>Atazanavir</b> <b>Bedaquiline</b> <b>Bosutinib</b> <b>Buprenorphine</b> <b>Ceritinib</b> <b>Cilostazol</b> <b>Cinacalcet</b> <b>Cisapride</b> (Special Access) <b>Cocaine</b> <b>Crizotinib</b> <b>Cyclosporine</b> <b>Dasatinib</b> <b>Degarelix</b> <b>Donepezil</b> <b>Enzalutamide</b> <b>Eribulin</b> <b>Fingolimod</b> <b>Foscarnet</b> <b>Galantamine</b></p> <p><b>Ginseng</b> <b>Goserelin</b> <b>Histrelin</b> <b>Hydroxyzine</b> <b>Indapamide</b> <b>Kaletra</b> <b>Lapatinib</b> <b>Levatinib</b> <b>Leuprolide</b> <b>Levomethadyl</b> <b>Lopinavir</b> <b>Methadone</b> <b>Midodrine</b> <b>Mifepristone</b> <b>Mirabegron</b> <b>Nilotinib</b> <b>Octeotide</b> <b>Orphenadrine</b> <b>Oxytocin</b> <b>Oxycodone</b> <b>Panobinostat</b> <b>Pasireotide</b> <b>Pazopanib</b> <b>Phenylephrine</b></p> <p><b>Probuco</b> <b>Propofol</b> <b>Propoxyphene</b> <b>Pseudoephedrine</b> <b>Rilpivirine</b> <small>≥ 75mg/day</small> <b>Ritodrine</b> <b>Ritonavir</b> <b>Romidepsin</b> <b>Saquinavir</b> <b>Sevoflurane</b> <b>Sibutramine</b> <b>Solifenacin</b> <b>Sorafenib</b> <b>Sunitinib</b> <b>Tacrolimus</b> <b>Tamoxifen</b> <b>Telaprevir</b> <b>Tizanidine</b> <b>Tolterodine</b> <b>Torsemide</b> <b>Triptorelin</b> <b>Vandetanib</b> <b>Vardenafil</b> <b>Vemurafenib</b></p>	<p><b>CYP3A4</b></p> <p><b>Amiodarone</b></p> <p><b>Azole antifungals:</b></p> <ul style="list-style-type: none"> <li>Fluconazole</li> <li>Itraconazole</li> <li>Ketoconazole</li> </ul> <p><b>Calcium channel blocker:</b></p> <ul style="list-style-type: none"> <li>Diltiazem</li> <li>Verapamil</li> </ul> <p><b>Cimetidine</b> <b>Ciprofloxacin</b> <b>Grapefruit juice</b></p> <p><b>HIV: protease inhibitors</b></p> <p><b>Macrolides:</b></p> <ul style="list-style-type: none"> <li>Erythromycin</li> <li>Clarithromycin</li> <li>Troleandomycin (not with Azithromycin)</li> </ul> <p><b>Methadone</b> <b>Telithromycin</b></p> <p><b>SSRIs:</b></p> <ul style="list-style-type: none"> <li>Fluoxetine</li> <li>Fluvoxamine</li> <li>Nefazodone</li> <li>Paroxetine</li> </ul> <p><b>Trazodone</b></p> <p><b>CYP2D6</b></p> <p><b>Beta-Blockers (BBs)</b> <b>Haloperidol</b> <b>Phenothiazines</b> <b>Quinidine</b> <b>SSRIs</b> (does not interact with citalopram) <b>Terbinafine</b> <b>TCAs</b></p> <p><b>CYP1A2 (less significant)</b></p> <p><b>Fluoroquinolones</b> <b>Fluvoxamine</b> <b>Grapefruit juice</b></p>
<p>AVOID combinations of phenothiazines with TCAs, βBs, &amp; anticonvulsants</p> <p>Some drugs (e.g. erythromycin &amp; amiodarone) prolong the QT interval AND act as inhibitors to potentially increase levels or QT effects of concomitant medications.</p>				

Major significance (well-documented); Low to moderate significance (fewer case reports); Minor significance (theoretical, few if any case reports)

**Comments:**

1. **No list is all inclusive and it is conceivable a medication that interacts with methadone or causes QTc prolongation may not appear on the list.**
2. Management of potential drug interactions requires clinical judgment with consideration of drug and patient specific factors. In some cases, no specific action may be required, while in other cases close monitoring and/or changes in drug therapy might be warranted when an interaction is noted.

Practitioners wanting more information on the nature of these drug interactions are encouraged to:

Contact **MedSask** for any medication-related queries at:



**1-800-667-3425**

(Within Saskatchewan)

OR

<http://medsask.usask.ca/index.php>

Call **PADIS** (Poison and Drug Information Services) at:

**1-866-454-1212** (Within Saskatchewan)

## Appendix G: Diagnostic Criteria for Opioid Use Disorder<sup>6</sup>

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
  - a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  - b. A markedly diminished effect with continued use of the same amount of an opioid. Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

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<sup>6</sup> Diagnostic and Statistical Manual of Mental Disorders V, Text Revision, Copyright 2013, American Psychiatric Association.

\*Please note that in May 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-V, was published. The section Substance Use Disorders now combines substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance is addressed as a separate use disorder (e.g. opioid use disorder). For more information on the revised chapter of "Substance Use Disorder), please see the following link:

<http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf>

11. Withdrawal, as manifested by either of the following:

- a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
- b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

*Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.*

*Specify if:*

- **In early remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).
- **In sustained remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

*Specify if:*

- **On maintenance therapy:** This additional specifier is used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.
- **In a controlled environment:** This additional specifier is used if the individual is in an environment where access to opioids is restricted.

# Appendix H: Initial Patient Assessment Form



Patient _____ HSN _____ DOB _____ Date _____	Expectations? Goals? Why treatment?
Drug of choice	Second drug of choice

### Addiction history

[c = current (past three months); p = past] Include all: opioids, alcohol, benzodiazepines, cocaine, amphetamines, prescription stimulants, hallucinogens, solvents, tobacco, cannabis, steroids

Substance/first use		Route/progression/typical amount/frequency	Last use
	c		
	p		
	c		
	p		
	c		
	p		

How drug use started:

How opioid use started:

Length of opioid addiction:

### Drug Attitudes

What patient likes about opioid use:

What patient dislikes about opioid use:

Perceived control over drug use: Yes  No

### Triggers

**Drug Behaviour**

Present needle injection: \_\_\_\_/day at peak: \_\_\_\_/day

Needle source: \_\_\_\_\_

**Opioid Source**

Current: \_\_\_\_\_

Money spent on drugs:

Source of money spent on drugs:

**Risk Behaviours****Current****Past**

Needle sharing		
Crime		
Driving		
Safe sex		
Sex work		

**Other Addictions****Current****Past**

Gambling		
Food		
Videogames		
Porn		
Shopping		

**DSM Criteria**

Need for increasing dose over time: Yes  No

Used more than planned: Yes  No

Drug overdoses: Yes  No

Hospital admissions or other significant health consequences resulting from drug related illness:

Yes  No

Presence of withdrawal symptoms (*dysphoria, insomnia, myalgia, lacrimation/rhinorrhea, sweating, piloerection, papillary dilation, nausea/vomiting/diarrhea*):

**Addiction Treatment**

Past treatment of addiction (detox, structured treatment program, methadone, NA/AA):

**Immunization** (HAV, HBV): \_\_\_\_\_ Date:

Current medications (prescribed, OTC, herbal, contraception):

\_\_\_\_\_  
\_\_\_\_\_

Allergies:

\_\_\_\_\_

Current MDs:

\_\_\_\_\_

Current medical problems (including HIV, HCV, psychiatric):

\_\_\_\_\_

History (admissions):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family history** (addiction, psychiatric, ischemic heart disease, hypertension, stroke, diabetes, cancer, respiratory (emphysema/COPD), neurologic (Parkinson's), liver)

**In women:**

G:  P:  TA:  Miscarriage:  Adopted out:

First day of LMP: \_\_\_\_\_

Menstrual cycle characteristics: \_\_\_\_\_

Current contraception method: \_\_\_\_\_

**Domestic Violence Assessment**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Financial

Employment

Education

Drug plan

Relationship

Family

Children

Housing

Legal

Sexual



Plan: Summary	Completed	Notes
Discuss OAT benefits and drawback		
Buprenorphine/naloxone (or) methadone (or) – start date and dose		
Initial blood work (CBC, Lytes, AST, ALT, GGT, TBili, ALP, Cr, BUN, Albumin, INR, PTT, FBG, Lipids: TC, TG, LDL, HDL, TSH)		
Pre-test counselling for HIV, Hep BsAg, Hep Cab, VDRL/RPR +/-bHCG		
Tuberculosis Test		
Pregnancy Test **if needed for women of childbearing age		
STI test **if at risk of infection (e.g. street involved, multiple partners)		
ECG **if considering methadone treatment		
Contract signed		
Urine Toxicology Test		
Sign release of info for past records		
PIP eHealth viewer profile obtained		
Psychosocial support plan		

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**OAT Clinical Note – SAMPLE**

**Patient:**

**Date:**

<i>Current OAT (circle)</i>	Methadone or buprenorphine/naloxone
<i>Current dose</i>	mg
<i>Number of take-home doses</i>	
<i>Missed doses</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

	None	Mild	Moderate	Severe
<i>Opioid cravings</i>				
<i>Opioid withdrawals</i>				

*Opiate Withdrawal Symptoms (circle):*

None   Insomnia   Anxiety   Dysphoria   Nausea   Diarrhea   Hot flashes   Irritability   Myalgia  
Restlessness

Rhinorrhea   Sneezing   Sweats   Yawning   Pupil dilated   Malaise   Abdominal cramping   Piloerection

*Timing of Withdrawal from last dose*

*Counselling / Clinical Notes:*

*Plan*

*Rx:*                      mg   po od from \_\_\_\_\_ to \_\_\_\_\_

*Take-home doses: M T W Th F Sa Su      for \_\_\_\_\_ week(s)*

*RTC*                                      *day / week*

<b>Psychological Issues</b>			<b>Notes</b>
<i>Mood</i>	Normal	Other	
<i>Sleep</i>	Normal	Insomnia	
<i>Anxiety</i>	Absent	Present	
<i>Energy</i>	Normal	Other	
<i>Suicidal Ideation</i>	Absent	Present	

<b>Patient stated since last visit</b>	<b>Yes</b>	<b>No</b>	<b>Route</b>	<b>Notes</b>
<i>Opiates</i>				
<i>Cocaine</i>				
<i>Benzodiazepine</i>				
<i>Alcohol</i>				
<i>Other problematic drug use</i>				
<i>Reported methadone sedation</i>			-	
<i>Reported withdrawal</i>			-	
<i>Take-home dose safety issues discussed</i>			-	
<i>Take-home dose locked up in a box</i>			-	
<i>Stable housing</i>			-	
<i>Stable employment / Social support</i>			-	
<i>Reviewed dangers of OAT diversion</i>			-	

O/E:

Notes

<i>Appearance</i>	Alert	Intoxicated	
<i>Behavior</i>	Normal	Abnormal	
<i>Gait</i>	Normal	Abnormal	
<i>Speech</i>	Normal	Abnormal	
<i>Eye contact</i>	Normal	Abnormal	

Supervised RUDS: O/E

Buprenorphine: \_\_\_\_\_

Methadone: \_\_\_\_\_

Cocaine: \_\_\_\_\_

Opiates: \_\_\_\_\_

Oxycodone: \_\_\_\_\_

Benzodiazepine: \_\_\_\_\_

Creatinine: Normal / Abnormal

Interpretation of UDS: \_\_\_\_\_

## Appendix I: Transfer of Care to Another OAT Provider



### FAX

**TO:** \_\_\_\_\_ **FROM:** \_\_\_\_\_  
**FAX:** \_\_\_\_\_ **FAX:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
**DATE:** \_\_\_\_\_  
**SUBJECT: PATIENT TRANSFER (Opioid Agonist Therapy)**

---

Dear Dr.

Please be advised that

Patient Name:

Patient HSN:

Patient DOB:

has transferred to Dr. \_\_\_\_\_ who will provide OAT services, commencing \_\_\_\_\_  
(Date)

To facilitate this transfer and ensure seamless care, please provide the following information unless circumstances prevent, in a timely fashion:

- Current OAT dose and take-home schedule;
- Summary of the patient's current recovery status (e.g. stable, worsening or urgent/emergent; key symptoms and findings/any red flags);
- Other:

I confirm that the patient has consented to the release of this information.

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Date)

**CONFIDENTIALITY WARNING:** The content of this transmission is confidential information and is intended solely for the use of the individual or entity to whom it is addressed. All other recipients are prohibited from disclosing, copying, using, distributing or taking any action in reliance on the contents. If you have received this fax in error, please notify the sender immediately.

## Appendix J: Process (behavioural) Addictions<sup>7</sup>

General addictions information can be found here:

<https://www.camh.ca/-/media/files/guides-and-publications/addiction-guide-en.pdf>

Process addictions frequently occur in patients with substance use disorders. Substance use, and behavioural addictions share common characteristics:

- Cravings
- Loss of control
- Compulsive use
- Use despite consequences

Examples of process addictions include but are not limited to the following areas:

- Gambling
- Sexual behaviours such as use of pornography, internet, or sex trade workers
- Compulsive shopping, spending, or shoplifting
- Eating disorders
- Compulsive exercise or work behaviours

Due to the connection between process addictions and substance use disorders, screening of patients for process addictions at the initial evaluation and on an intermittent basis is recommended. Evaluation for process addictions should be incorporated into a yearly review or used in the evaluation of recurrent relapse or failure to progress through stages of recovery.

The following are clinical screening tools useful in assessing process addictions:

- 1) **GAMBLING**
  - i. [South Oaks Gambling Screen](#)
  - ii. [Canadian Problem Gambling index](#)
  - iii. [Gamblers Anonymous 20 Questions](#)
  
- 2) **SEXUAL ADDICTION**
  - i. [Sexual Addictions Screening Test \(SAST\)](#)

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<sup>7</sup> College of Physicians & Surgeons of Nova Scotia. (2012). *CPSNS Methadone Maintenance Treatment Handbook* (pp.99)  
Retrieved from  
<http://druglibrary.wordpress.stir.ac.uk/files/2017/07/guideline-methadone-maintenance.pdf>

## Appendix K: Treatment Agreement Sample

This is an agreement for Opioid Agonist Therapy between

_____	and	_____
(patient/client)		(physician/clinic)
<ol style="list-style-type: none"><li>1. I understand that the doctor will perform an assessment and medical examination, will establish the diagnosis of an Opioid Use Disorder, and will prescribe OAT if it is considered appropriate and safe for me.</li><li>2. I agree to take OAT under medical direction, to assist me in dealing with my opioid use disorder. I have tried or considered other treatment options. I understand that OAT is generally a long-term treatment.</li><li>3. I understand that I will become physically dependent on OAT and will experience withdrawal symptoms if I suddenly stop taking it.</li><li>4. I understand that OAT may cause drowsiness especially when starting treatment or when I receive increases in my dose. As a result, this may impair my ability in operating motor vehicles.</li><li>5. I am aware that the OAT team may consist of several professionals including doctors, pharmacists, nurses, counsellors, social workers and support staff, who will be in close communication with each other to assure safety in my care.</li><li>6. For safety reasons, the prescribing doctor will contact my maintaining doctor to ensure that each is fully aware of the treatment being provided by the other.</li><li>7. I recognize that counselling and other addiction assessments are available to assist me in dealing with the psychological and social difficulties that can accompany problems of opioid use disorder.</li></ol>		<ol style="list-style-type: none"><li>8. I understand that when on OAT, taking other opioids (e.g. Tylenol® #1, 2, 3, 4, codeine, morphine, oxycodone, hydromorphone, fentanyl) and/or other substances, especially alcohol and benzodiazepines (Ativan®, Lectopam®, Restoril®, Rivotril®, Serax®, Valium®, Xanax®) could be dangerous, especially if taken in excess. These drugs may interact with my OAT and cause overdose, coma, or even death.</li><li>9. I agree that when I see another doctor or dentist, I will inform them that I am taking OAT. I agree to provide copies of any prescriptions obtained by me for medical reasons to be reviewed by the maintenance doctor. The treatment team, if necessary, may do follow up with the prescription doctor. I understand that in certain cases, the prescribing doctor might not feel comfortable with prescribing OAT to me in combination with other medications that I have been prescribed.</li><li>10. I understand that initially I will be required to consume OAT daily under the direct observation of a pharmacist or other qualified health care professional. Even after carry privileges have been granted (see #11), I will still be required intermittently to drink a dose of my OAT under direct pharmacy or health care supervision.</li><li>11. I am aware that I may be granted a limited number of take-home carries of OAT once I have demonstrated sufficiently that I am no longer continuing to use illicit and/or other non-prescribed drugs and have made obvious positive and stable lifestyle changes. Carries may also be considered for specific reasons</li></ol>

such as work/school. Carry privileges may not be provided if I miss clinic or medical appointments, not provide urine samples for toxicology testing when requested, misuse or divert my carries, as examples.

12. I realize that OAT can be fatal to others and will keep the medication in my possession secure.
13. I understand that I must satisfy the doctor prescribing OAT for me that I have made all necessary arrangements to ensure the safety of myself and others, where carries are involved. This may include transporting and storing carries in a locked box or other secure container.
14. I realize that if I use my carries inappropriately, further carries will be suspended.
15. I understand that missed doses will be recorded on my file and will result in actions to ensure my safety. These may include a reduction or suspension of my dosage until I am reassessed.
16. I understand that the College of Physicians and Surgeons of Saskatchewan (CPSS), Prescription Review Program (PRP) monitors OAT prescriptions, and as such my prescription information will be recorded. This may involve the occasional review of my file by an external reviewer to ensure that my medical treatment is delivered in a safe manner. None of the information on my file will be given to anyone outside this review process.

17. I understand that all clinical information on my file is confidential and will not be released to anyone without my written consent, except where staff believes there is a medical emergency and intervention is required by clinical staff and/or other persons.
18. I agree to attend ongoing medical examinations, urine drug testing, other laboratory testing, and counselling appointments when required.
19. A witnessed collection may be required in the following examples: an invalid sample based on its temperature, results or repeated missed appointments for the required urine drug testing.
20. I agree to behave in a respectful manner toward all treatment team members and other patients/clients.
21. I understand that any violence, threats of violence, verbal abuse or disruptive behaviour, or diversion of my OAT, will not be tolerated and could result in my termination from treatment.
22. I understand that my dose may be decreased and then stopped if it is determined that I am not benefitting from OAT. Involuntary withdrawal from OAT may be more rapid if it is medically indicated for my safety or the safety of others.
23. I understand that it is my responsibility to be aware that my prescription is coming due and take the appropriate steps (e.g. make an appointment to see my doctor) to get it filled.

The undersigned fully understands the conditions of this agreement, agrees to the provisions in full and has received a copy of this document.

\_\_\_\_\_  
Patient/client signature

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## College of Pharmacists Three-Way Agreement<sup>8</sup>

Your prescriber prescribed Opioid Agonist Therapy (OAT) for your opioid use disorder. Our pharmacy will provide the services for treatment. OAT is generally taken long-term and will require your commitment and responsibility to take the medication only as prescribed. A pharmacist will determine if it is safe for you to take your daily dose and then watch you as you ingest the dose. Observation of daily doses will continue until your doctor considers that you may be ready to try take-home doses.

**\*\*Some patients may never be considered for take-home doses if their personal safety and the safety of the community are of concern. \*\***

Your doctor or program service providers and pharmacist will work together to support you. They may consult each other, your family doctor (as applicable), or other members of your treatment team if issues and concerns arise as you progress with your treatment. You are also welcomed to consult your doctor or pharmacist as needed if you have concerns about your condition or your treatment.

This agreement is between:

Your pharmacy and its staff

Your prescriber

You, our patient

This agreement outlines responsibilities and obligations of each party to ensure a mutual understanding and awareness of the expectations involved in our collaboration.

The entire agreement is detailed in the following pages.

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<sup>8</sup> College of Physicians & Surgeons of Alberta. (2015). *Alberta Methadone Maintenance Treatment; Standards and Guidelines for Dependence*. (p. 42) retrieved from [https://abpharmacy.ca/sites/default/files/OAT\\_Guidelines.pdf](https://abpharmacy.ca/sites/default/files/OAT_Guidelines.pdf)

Your pharmacy agrees 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 OAT 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 private and health information. Your private information will only be shared with your consent or if we are required by law.
- Ongoing monitoring of your response and progress with OAT while you remain under the pharmacy's care.

Your doctor agrees to provide you with the following:

- Professional, non-judgmental, services that recognize your rights to respect and personal dignity.
- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.
- Regularly scheduled appointments offered at a frequency that is deemed necessary for your personal health and safety and that is based on your progress and needs while on OAT.
- Ongoing monitoring of your response and progress with methadone while you remain in his or her care.
- Privacy and confidentiality with your private and health information. Your private information will only be shared with your consent or if required by law.

As the patient on treatment, I agree to:

- Take OAT for treatment for my opioid use disorder. I will take it as prescribed by my doctor. I will let my doctor and/or pharmacist know if I am experiencing any withdrawal effects or any side effects from the treatment.
- Keep my appointments with my doctor. I know that my doses of OAT will only be prescribed if my doctor can monitor my response and progress. If I do not keep my appointments, my doctor may no longer be able to prescribe the drug to me.
- Keep my regular daily meeting with my pharmacy to receive my dose. I will make every effort to be punctual and reliable and I will call the pharmacy if I am going to be late. If I am not compliant with my daily doses, I am aware that my treatment may have to stop as it can pose a danger to me to have inconsistent dosing with methadone.
- Bring and show my photo ID each time I visit my pharmacy for my daily dose.
- The pharmacy calling my doctor they have any concerns about my safety on the treatment(s).
- The pharmacy calling my doctor if a dose is missed, lost, stolen, and/or partially administered.

- Call the local police, as well as my pharmacist and my doctor, if I lose a dose or if a dose in my possession is stolen, as the drug may be dangerous to the community.
- Inform any other doctor, dentist, or pharmacy that I am on OAT. I will also inform my pharmacy and doctor of any other medication that I am prescribed as I realize that some treatments may interact with OAT and cause harm to me. My doctor may be more aware of this issue than a doctor not trained in this specialized treatment.
- Keep both my doctor and pharmacist informed of all the drugs (prescription and non-prescription) that I am taking, including natural health products and vitamins.
- Take urine tests or other tests required to monitor progress and safety on treatment as directed by my doctor or pharmacist.
- Be polite and respectful while on the premises of the pharmacy. I agree that I will not be disruptive, violent, abusive, or threaten or cause harm to anyone or to any property. I acknowledge that bad behaviour may result in the termination of my services from the pharmacy. Also, some offences may be brought to the attention of law enforcement as determined by provincial and federal legislation.

As the patient on OAT, I am aware that:

- The pharmacy will not provide me with my OAT dose if I arrive intoxicated or with other symptoms where taking the dose may be harmful to me.
- I agree not to drive or operate machinery that requires my alertness when I am being initiated on therapy (typically the first two weeks) or when I am having doses adjusted or if I am having treatment effects that are making me sleepy and not alert.
- Taking narcotics, sleeping pills, alcohol, or other sedating substances may interact with OAT to cause overdose, coma, or even death. I will not take other medications unless prescribed by either my methadone or pain doctor or my family doctor (if different).
- Through this agreement, I have been made aware that in Saskatchewan, the laws that govern physicians and pharmacists require that prescription information will be recorded. This may involve occasional review of my file by an external reviewer working within the regulatory colleges of physicians or pharmacists to view my health files or the pharmacy's prescription files. I am aware this is a legal requirement that my prescriber and pharmacist do not control that is part of the regular auditing and inspection process of their respective governing bodies. I understand that my personal health information may be shared in such circumstances as required by law.

_____	_____
Patient signature	Date
_____	_____
Pharmacy representative signature	Date
_____	_____
Prescriber signature	Date

## Appendix L: Sample Dispensing Schedule

<b>( sticker )</b>	<b>Dr. B Sample ABC Clinic</b> 111 10th Street N Sometown, Saskatchewan Canada S0A 0T4 Tel: ( 306 ) 222-1111 FAX: (306) 222-1234	
<hr/>		
<input type="checkbox"/> Pharmacy A	<input type="checkbox"/> Pharmacy B	<input type="checkbox"/> Pharmacy C
<input type="checkbox"/> Other pharmacy: _____		
<i>Prescriber Certification:</i>		
<ul style="list-style-type: none"><li>▪ This prescription represents the original prescription drug order.</li><li>▪ The pharmacy address noted above is the only intended recipient for dispensing.</li><li>▪ This prescription will be securely filled and not transmitted elsewhere at another time.</li></ul>		
<i>Prescription valid only for 3 days from date of issue/start date.</i>		
<i>Prescription is void if not faxed from Methadone Assisted Recovery Program</i>		
<b>RX:</b>		
Methadone _____ mg po od		
Start Date:		
End Date:		
Witness: Daily unless closed or Mon – Tue – Wed – Thur – Fri – Sat – Sun		
Carry: Mon – Tue – Wed – Thur – Fri – Sat – Sun		
<hr/>		
Other Medications:		
Signature: _____		
Prescriber ID # _____		
Next Appointment:		

## Appendix M: Opioid Withdrawal and Tolerance

Prescribers must be familiar with the clinical features of opioid withdrawal.

### Opioid Withdrawal

Opioid withdrawal peaks at 2 to 3 days after the last use. Physical symptoms largely resolve by 5 to 10 days, although psychological symptoms can continue for weeks or months.

Serious complications of withdrawal include miscarriage, premature labour, suicide, and overdose or relapse due to loss of tolerance.

Opioid Withdrawal Signs and Symptoms		
Physical Symptoms	Psychological Symptoms	Physical Signs
Myalgia	Restlessness	Lacrimation
Abdominal cramps	Dysphoria	Rhinorrhea
Nausea	Insomnia	Dilated pupils
Chills	Anxiety	Abdominal tenderness
Hot flashes	Irritability	
Electric or uncomfortable	Fatigue	Vomiting
Yawning	Drug craving (the insomnia and anxiety may be severe and distressing)	Diarrhea
		Sweating
		Chills
		Piloerection
		Tachycardia
		Hypertension

The patient on inadequate doses of OAT will describe a characteristic set of symptoms. The symptoms appear a certain number of hours after the dose of OAT, although there may be some variation with the patient's activity level and other factors. The onset of symptoms is delayed with each dose increase.

Alternative explanations should be sought if the patient:

- gives an inconsistent history of withdrawal symptoms;
- has one isolated symptom (such as insomnia or nausea);
- advises the onset of symptoms is not related to the time of the dose; or
- has been taking a stable dose and suddenly complains of withdrawal (see below).

A dose might be considered acceptable if the patient sleeps comfortably at night and only has mild withdrawal symptoms on awakening, which are tolerable to the patient.

### Conditions Commonly Confused with Withdrawal

The clinician should determine why the patient continues to report withdrawal symptoms despite dosage adjustment. Common reasons for ongoing withdrawal include:

- medication use that speeds methadone or buprenorphine metabolism (e.g. phenytoin, chronic alcohol use)
- opioid use
- diverting doses

Physicians should consider a medication review with the pharmacist. The following conditions cause symptoms that are confused with withdrawal:

**Pseudonormalization** should be suspected if the patient regularly complains some weeks after a dose increase that it is no longer ‘working.’ Patients who are mildly intoxicated on opioids feel more enthusiastic and energetic. As they develop tolerance, they may feel they need a dose increase to recreate this effect, which they view as both desirable and normal.

**Insomnia** is often the dominant symptom of opioid withdrawal. Other causes should be ruled out if the patient reports insomnia that isn’t accompanied by other withdrawal symptoms and is not relieved by a dose increase. Depression, anxiety, and use of alcohol and cocaine are common causes of insomnia in this population. A careful sleep history will identify day-night reversal, daytime napping and other causes of night-time insomnia. Careful instruction in sleep hygiene should be undertaken. Medication should be used only when the patient is on a stable dose of methadone and sleep hygiene counselling has failed. Trazodone or other non- benzodiazepine hypnotics are the treatments of choice.

**Sedation and Withdrawal Symptoms:** Occasionally patients report sedation several hours after dosing, with withdrawal symptoms and insomnia at night. The sedation may simply represent the onset of sleep following a night of insomnia due to withdrawal. The methadone dose might be too high, causing excessive sleep during the day and inadequate sleep at night. The patient may have day-night reversal, independent of the methadone dose.

**Other conditions:** Patients may be anticipating that an increase in their dose will manage symptoms that have little to do with withdrawal. Common examples include depression, anxiety, irritable bowel syndrome, and some forms of chronic pain. The physician should identify these symptoms, explain to the patient the limitations of OAT, and assist the patient in finding an appropriate management strategy.

### Diagnostic Criteria for Opioid Withdrawal

1. *Either of the following:*
  - a. cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
  - b. administration of an opioid antagonist after a period of opioid use

2. *Three (or more) of the following: developing within minutes to several days after Criterion A:*
  - a. dysphoric mood
  - b. nausea or vomiting
  - c. muscle aches
  - d. lacrimation or rhinorrhea
  - e. papillary dilation, piloerection or sweating
  - f. diarrhea
  - g. yawning
  - h. fever
  - i. Insomnia
3. *The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational or other important areas of functioning.*
4. *The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.*

Treatment for opioid withdrawal:

Medication-based withdrawal management recommended over abrupt cessation. In OUD patients there is evidence supporting the use of more gradual tapers to reduce risk of relapse. Tapered doses of partial (buprenorphine) or full (methadone) opioid agonist generally recommended but alpha-2 adrenergic agonists (clonidine) may also be used.

RxFiles tapering tool: <http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf>

Opioid taper option <sup>9,</sup> <sub>10</sub>			
<b>First line</b>  Between the two* generally use the same medication used for maintenance treatment	Buprenorphine	Slightly more effective than methadone  More effective than alpha-2 agonists  Less severe withdrawal  Associated with higher treatment completion rates	Taper should be at least 5 days  Buprenorphine may lessen withdrawal symptoms and increase time in treatment compared to alpha-2 adrenergic agonists for patients undergoing opioid withdrawal
	Methadone	No risk of precipitated withdrawal  Cheaper	Taper should be at least 10 days  Tapered methadone associated with similar abstinence rates as other pharmacologic treatments for opiate withdrawal
<b>Second line</b>	Alpha-2 agonists	May be effective for management of opioid withdrawal and be as effective as tapered methadone  Lofexidine preferred over clonidine b/c less adverse effects  Clonidine is recommended as support for opioid withdrawal	Potential for hypotension with clonidine may limit use  Do not use clonidine for opioid detoxification

\*\*Subacute withdrawal symptoms, such as anhedonia, fatigue, insomnia, or anorexia, may persist for weeks or months after acute symptoms resolve

<sup>99</sup>DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 –Available from <http://www.dynamed.com>. Registration and login required.

<sup>10</sup> College of Physicians & Surgeons and Nova Scotia, College of Registered Nurses of Nova Scotia. (2017). *Methadone Maintenance Treatment Handbook*. (p. 17) Retrieved from <https://cpsns.ns.ca/wp-content/uploads/2017/10/Methadone-Maintenance-Treatment-Handbook.pdf>

Other withdrawal related side effects			Dose
Aches and pains	NSAIDs	<i>Ibuprofen</i>	400-600mg four times daily
		<i>Naproxen</i>	375-500 mg twice daily
	<i>Acetaminophen</i>		650-1000mg every 6 hours as needed
	<i>Cyclobenzaprine</i>		5-10mg every 4 to 6 hours for muscle spasms (maximum dose 30mg/24hours)
	<i>Ketorolac</i>		30 mg IM injection every 6 hours (max dose 120mg/24 hours)
Diarrhea	<i>Loperamide</i>		Used if necessary 2mg after each loose stool
Nausea	<i>Trimethobenzamide</i>		250 mg oral every 6 hours (or 200mg IM)
	<i>Metoclopramide</i>		10 mg every 4 to 6 hours
	<i>Prochlorperazine</i>		5 mg orally every 4 to 6 hours
	<i>Promethazine</i>		25 mg orally or IM every 4 to 6 hours as needed (max dose 50mg/24hours)
	<i>Ondansetron</i>		8-16mg orally every 8 to 12 hours
Sweating	<i>Oxybutynin</i>		2.5-5mg twice daily as needed
itchiness, lacrimation, cramps, rhinorrhea, diaphoresis, insomnia	<i>Hydroxyzine</i>		25 to 50 three times daily as needed, or  sometimes just needed before bed (short term)
Agitation anxiety or restless legs	Benzodiazepines	<i>Clonazepam</i>	0.5-2 mg orally every 4 to 6 hours (max 6mg/24hrs)
		<i>diazepam</i>	5mg orally 4 times a day
	Antihistamines	<i>Diphenhydramine</i>	50 to 100 mg every 4 to 6 hours (max 300 mg/24hrs)
		<i>Hydroxyzine</i>	100-150 mg every 6 hours (max 600mg/24hrs)
	Insomnia anxiety and pain	<i>Gabapentin</i>	300mg before bed
		<i>Pregabalin</i>	75 mg before bed
<i>Nabilone</i>		0.25X-0.5mg HS up to 0.5-1.0mg TID	
Insomnia	<i>Trazodone</i>		50 to 150 mg orally at bedtime
	<i>Doxepin</i>		50 to 100 mg orally at bedtime
	<i>Amitriptyline</i>		10mg orally at bedtime
Physical withdrawal SXS (e.g. agitation)	<i>Clonidine</i>		0.1 mg twice a day as needed

## Appendix N: A Patients Guide<sup>11</sup>

### A PATIENT'S GUIDE – AVOIDING OVERDOSE IN THE FIRST TWO WEEKS OF METHADONE TREATMENT

The clinic provides methadone care as safely as possible, but accidental overdoses sometimes happen in the first two weeks of treatment. The questions and answers below will help you to get through this period safely. Share this information sheet with a friend or family member.

#### **Why can't my doctor increase my dose more quickly?**

When you first start taking methadone, you want to get on the right dose as soon as possible. However, your doctor must increase your dose slowly over several weeks because your body takes time to adjust to methadone, and (unlike other narcotics), methadone builds up slowly in your bloodstream over several days. A dose that may feel like too little on a Monday could put you in hospital by Thursday.

#### **What can I take to relieve withdrawal and help me sleep until the methadone begins to work?**

Only take medications that are approved by your methadone doctor. If you're on a medication prescribed by another doctor, your methadone doctor needs to approve it because it could interact with the methadone.

Substances that make you relaxed or sleepy can be dangerous. This includes alcohol, opioids, benzodiazepines (Ativan, Valium, Xanax, Restoril, etc.), antihistamines (such as Gravol<sup>®</sup> or Benadryl), and certain types of antidepressants and tranquilizers.

Even certain antibiotics can be dangerous as they block the breakdown of methadone in the body. So make sure to check all your medications with your methadone physician.

#### **Isn't methadone supposed to make you sleepy?**

No. You are supposed to feel normal on methadone, not high or sleepy. Methadone builds up so slowly that it happens only occasionally that someone can feel a bit sleepy during the day, lie down for a nap and not wake up. So please take the following precautions:

- Take your methadone at the same time each day.
- See your doctor or case manager at least twice a week for the first two weeks. (Many clinics will require visits that are more frequent.)
- Discuss your methadone treatment with a close friend or family member. If they see that you're drowsy, they must call your methadone doctor or an ambulance.

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<sup>11</sup> College of Physicians and Surgeons of Manitoba. (2016). *Manitoba Methadone & Buprenorphine Maintenance*. (p.12) Retrieved from <https://cpsm.mb.ca/assets/PrescribingPracticesProgram/Recommended%20Practice%20Book%20Methadone.pdf>

**What are some of the symptoms if my methadone dose is too high?**

- You may feel sleepy, and nod off several times during the day.
- You may be forgetful.
- You may be difficult to wake up from your sleep.
- You may experience slurred speech, stumbling walk, or appear drunk.
- If these things are occurring, you must call your doctor immediately or go to an emergency department as you may be overdosing.

**I've been offered a small amount of methadone by a methadone patient at the pharmacy. This can't hurt – I know I need 80 mg!**

Above all, don't take any extra methadone! It's probably safe for your friend but could be lethal for you. It may be true that you took 80 mg **once** and were okay. If you had taken 80 mg every day for three or four days, you might have died. Remember, it takes five days for a certain dose to build up in your blood.

## Appendix O: Patients at High Risk for Methadone Toxicity<sup>12</sup>

An initial dose of 10 to 20 mg with careful dosage titration is recommended for the high-risk patients described below. The care of these patients frequently warrants telephone consultation with an experienced addiction physician.

### **Patients recently using benzodiazepines**

Patients recently abusing benzodiazepines or using these drugs for therapeutic purposes are high-risk patients. An exception might be the patient who has been on a small HS dose for at least several months.

### **Patients using other sedating drugs**

Patients using antipsychotic and sedating antidepressants are at high risk, particularly if the sedating drug was started or increased within the last two months, or the dose is moderate or high.

### **Problem drinkers and alcohol-dependent patients**

Problematic alcohol use can be identified through an alcohol history and laboratory measures (GGT and MCV). All patients should be advised to abstain from alcohol during early stabilization. If the patient is at significant risk for alcohol withdrawal, the patient needs appropriate alcohol detoxification.

### **Patients who are older (>60 years) and have a respiratory illness**

This group includes patients with chronic illnesses such as COPD and acute illnesses such as pneumonia.

### **Patients who are on drugs that inhibit/promote methadone metabolism**

If a drug that inhibits metabolism is meant for short-term use only, the physician might recommend that the patient finish the course before prescribing methadone. Conversely, patients on medications that promote rapid methadone metabolism should avoid abrupt cessation of the medication.

### **Patients with lower opioid tolerance**

Tolerance is difficult to establish from history; therefore, if in doubt, it is safer to initiate methadone at a lower dose. Lowered tolerance might be possible in patients who report non-daily opioid use, daily use of codeine, or daily use of oral opioids at moderate doses. A urine drug screen can be helpful in confirming the patient's self-reported use of opioids. (Urine drug screens may not detect synthetic opioids such as oxycodone and fentanyl and they do not indicate length or severity of use.)

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<sup>12</sup> College of Physicians and Surgeons of Manitoba. (2016). *Manitoba Methadone & Buprenorphine Maintenance*. (p.14) Retrieved from <https://cpsm.mb.ca/assets/PrescribingPracticesProgram/Recommended%20Practice%20Book%20Methadone.pdf>

## Appendix P: Key Indicators of Stability and Instability

### Indicators of Stability

The patient's level of stability and evaluation of the benefits of OAT are based on improvements in all areas of a patient's life. The following are some of the indicators of patient stability. These indicators should be considered when:

- *Planning a transfer of care from the Initiating Physician to a Maintaining Physician*
- *A patient has requested carries and/or a non-crystalline suspension of methadone*
- *A patient is considering a voluntary withdrawal from OAT*

*It is important to note that in many cases, while a patient's dose can be stable and effective, the patient himself/herself may never be considered truly stable.*

### Methadone Dosage and Use of Other Substances Indicators

- Reported suppression or elimination of opioid withdrawal symptoms
- Reported reduction or elimination of craving for opioids
- Reported and documented absence of over-sedation or euphoria on current dosage
- Reported evidence of the reduction or elimination in the number of injection drug-use events
- Demonstrated awareness of resources to obtain clean injection apparatus and knowledgeable in proper cleaning and non-sharing of equipment
- Demonstrated knowledge of the serious health consequences of CNS depressant use when combined with OAT
- Reported management of OAT-related side effects
- Evidence of unadulterated urine samples that are absent of prescribed substances
- Demonstrated personal and social stability
- Reported sense of well-being
- Reported active avoidance of situations that are recognized triggers for relapse
- Abstinent social support systems identified and in place
- Demonstrated efforts to achieve positive lifestyle changes
- Positive supportive information from treatment team members
- Demonstrated mechanisms in place for the safety and storage of carries

## Medical and Psychiatric Issue Indicators

- Documented stabilization of acute medical conditions
- Established attendance for ongoing health care for chronic conditions
- Demonstrated improvement in overall health status
- Noted improved dental health and hygiene
- Stable medical and mental health status
- No reports of accidental overdose
- The patient has an ongoing relationship with a primary care provider who has knowledge of or is the prescriber of the methadone

## Basic Necessities Indicators

- Provisions made for food, clothing, housing and safety needs and financial assistance if necessary
- Demonstrated management of basic personal care activities
- Relatively stable and secure living conditions
- Receipt of prenatal care
- Documented established childcare resources
- Transportation resources available
- Documented stable source of income
- Demonstrated involvement in productive activity: school, employment, volunteering
- Reported involvement in healthy and safe leisure activities

## Relationship Indicators

- Documented regular attendance for medication, UDS, counselling and medical appointments
- Documented follow up with appropriate resources as per patient assessment and agreed upon treatment goals
- Reported positive interactions with treatment team members
- Reported maintenance of positive support systems
- Reported absence of major conflict within family support system
- Reported resolution of, or ongoing efforts to resolve, legal problems
- Evidence of no illegal activities

## Indicators of Instability

- RUDS without the presence of OAT, or with the presence of drugs of abuse illicit or otherwise
- Fraudulent urine specimen
- Missed appointments or DWIs
- Multiple doctoring
- Unstable and insecure living arrangements and social environment
- Unstable dosing pattern
- Pattern of missed doses
- Evidence of unstable medical psychiatric and social instability

## Appendix Q: Reducing Risk<sup>13</sup>

The steps described below can help to reduce risk during the early stabilization phase.

### **No new prescriptions for sedating drugs**

Avoid prescribing any new sedating drugs during the early stabilization phase. Patients should also be advised to avoid alcohol and over-the-counter sedating drugs.

### **General advice to the patient and family**

Explain to the patient that it takes several weeks to reach the optimal dose of methadone, and that it is dangerous trying to relieve withdrawal symptoms with benzodiazepines, alcohol, opioids, illicit methadone, or other drugs. Advise the patient to limit his or her driving or use of machinery after a dose increase, particularly in the first few hours after dosing. Advise the patient to take the methadone dose in the morning, since the risk of overdose is increased at night. (See the patient's guide on page 12 to give to patients and family).

During the early stabilization phase, patients and their families (if the patient consents) should be educated about methadone toxicity.

### **Explaining the risks of diverted methadone**

*Even a single dose of methadone can be fatal to both children and adults.* Patients are responsible for the safe storage of their methadone. Physicians must advise patients that it is dangerous and illegal to sell or give methadone to anyone, even in small doses or done with good intentions.

### **Educating the patient and family members about signs of impending toxicity**

Whenever feasible (with the patient's consent), a family member or significant other should be educated about the symptoms of overdose or toxicity. Clear instructions should be given to contact their clinic or to go to the emergency department immediately at the first sign of toxicity. A patient information guide may be used for this purpose (see the patient's guide on page 12).

### **Carries during initial titration**

No carries should generally be granted during the first two months of treatment (except for Sunday carries). Some programs give weekend carries if the patient shows reliable behaviour; otherwise, daily witnessed ingestion is arranged.

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<sup>13</sup> College of Physicians and Surgeons of Manitoba. (2016). *Manitoba Methadone & Buprenorphine Maintenance*. (p.15) Retrieved from <https://cpsm.mb.ca/assets/PrescribingPracticesProgram/Recommended%20Practice%20Book%20Methadone.pdf>

**Missed doses**

During the early stabilization phase, patients should be on the same dose for three to four consecutive days with no missed dose before a dose increase. If a patient misses three or more doses consecutively, he or she should resume at the initial dose (10-30 mg) for at least three consecutive days.

**Negative initial urine drug screen and recent abstinence**

If patients who report no recent opioid use have a negative initial urine drug screen, methadone should not be initiated unless they have recently been abstinent in a supervised setting (incarceration, inpatient program, etc.). These patients should have a long history of opioid use disorder, strong urges to use opioids and/or a good response to MT in the past. The initial dose should be 5-10 mg, titrated upwards every five or more days in increments of 5 mg or less, with careful assessment of withdrawal symptoms and sedation. Repeat assessment and repeat urine drug screens may be indicated for some patients with initial negative urine drug screens.

## Appendix R: Urine Testing

Urine drug tests are one of the ongoing means of assessing progress of OAT, providing an informative window on issues around continued drug use, and on patients' behaviour generally. They can be used constructively to assist forward movement to good control of drug use and behaviour with the well documented benefits. They should only be used punitively as a last resort.

A urine drug screen is a panel of several tests done at one time. This can include stimulants like amphetamines, methylphenidate, or cocaine; depressants like barbiturates, benzodiazepines, opioids, methadone, buprenorphine (or its metabolite); others like PCP, ethyl alcohol, and cannabinoids.

1. Urine drug screens are done to ensure that patients are ingesting the OAT that is prescribed for them and to detect whether they are taking any other non-prescribed drugs. The validity of the urine screen results increases if the collection is done randomly under supervision.
2. A minimum of one urine drug screen is advised prior to initiation of OAT treatment.
3. Randomly collected urine samples ideally in an observed manner are the most useful in assessing patient progress in a treatment program.
4. For methadone prescribed patients testing should occur at least two times per month during the stabilization period.
5. The sample should be 50-60 mL, ideally collected in a bathroom with no hot water, then temperature tested, to reduce the possibility of tampering.
6. For functionally stable long-term patients it is recommended that random urine screens should be tested at least four times annually. The presence of illicit drugs and/or the unexplained absence of methadone or buprenorphine metabolites should be discussed with the patient and appropriate action taken; a more frequent testing schedule may well be necessary.
7. The physician has the right to request additional urine samples at any time. This should be clearly stated in the program treatment agreement.

Testing for "drugs of abuse" is performed by the Roy Romanow Provincial Laboratory (RRPL). It is important to understand how they test, and how to interpret the results. Laboratory procedures are changing rapidly and are occasionally subject to error; care is recommended in confronting patients with lab test reports.

Ideally, the lab tests for a combination of parent and/or metabolites of drugs, i.e. substances already altered by body metabolism and excreted in altered form in the urine. The Provincial Laboratory tests are shown on the following page.

Laboratory tests also have a minimum test level (the "cut-off") below which the results are reported as "negative", if the substance is present in smaller amounts. (See Table on the following page).

There are two different test procedures, a simple ELISA/EMIT (enzyme linked immunoassay) and the more complex Gas Liquid Chromatography / Mass Spectrometry ("GC/MS") confirmatory test. Most samples are tested by the ELISA/EMIT procedure. Gas Liquid Chromatography is done infrequently, and the GC/MS procedure is done only if essential, usually in medico-legal cases.

The comprehensive "drugs of abuse" screen done by the Roy Romanov provincial laboratory detects and identifies 40 common drugs/metabolites being: <sup>14</sup>

7-amino-clonazepam, 7-amino-flunitrazepam, alpha-hydroxy-alprazolam, alprazolam, amphetamine, benzoylecgonine, buprenorphine, clonazepam, cocaine, codeine, des-alkyl-flurazepam, diazepam, diphenhydramine, EDDP, fentanyl, flunitrazepam, flurazepam, gabapentin, hydrocodone, hydromorphone, ketamine, lorazepam, MDA, MDEA, MDMA, meperidine, methadone, methamphetamine, methylphenidate, morphine, norbuprenorphine, nordiazepam, norfentanyl, normeperidine, oxazepam, oxycodone, PCP, pseudoephedrine, ritalinic acid, temazepam, THC-COOH (cannabinoids), triazolam.

*\*\* barbiturates, ethanol, LSD, and others are available upon request\**

**Most drugs that are screened for are detected in urine for approximately 1-2 days only.**

**The labs turnaround time is ~2 days.**

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<sup>14</sup> <https://rrpl-testviewer.ehealthsask.ca/Home/Details?id=186>

## Urine Drug Screening Collection Practice

UDS are clinically reliable when urine collection is directly observed. However, other measures can be taken to enhance the authenticity of the urine sample and consequently the test results.

In most cases directly observing urine collection is not required.

- Temperature check to be performed immediately after urine sample is obtained, using a temperature sensitive strip.
- Lab staff does not witness urine collection.

If there is concern about the integrity of the sample, please notify the ordering physician's office, and indicate concerns on the requisition, providing all relevant details.

Chain of custody is for legal matters and does not apply to OAT.

The primary care physician may not have direct lab services in concert with the clinical practice and therefore patients will have a choice of labs for this service.

This document may be attached to the requisition for collection of urines to ensure the proper protocol is followed.

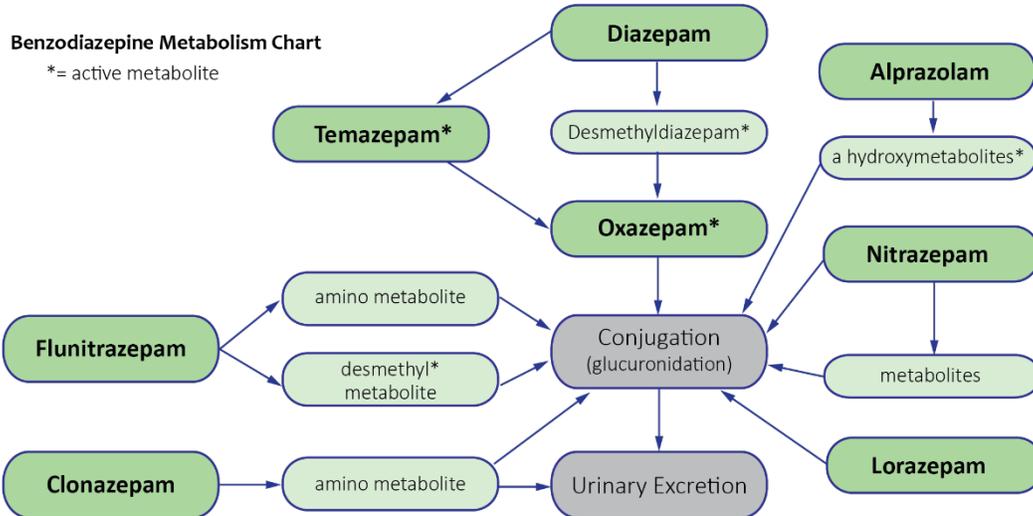
- Extra clothing such as coats and sweaters should be removed
- Parcels, bags and purses must not be taken into the collection area
- Patients should receive a pre-labelled urinalysis container prior to entering the collection area
- The patient must bring the sample directly to the collector and not place it in a pass-through-window
- No other urine samples should be accessible to the patient during the provision of the sample (e.g.: specimen pass-through cabinet).
- A minimum volume of 30 mL is required

### **Considerations:**

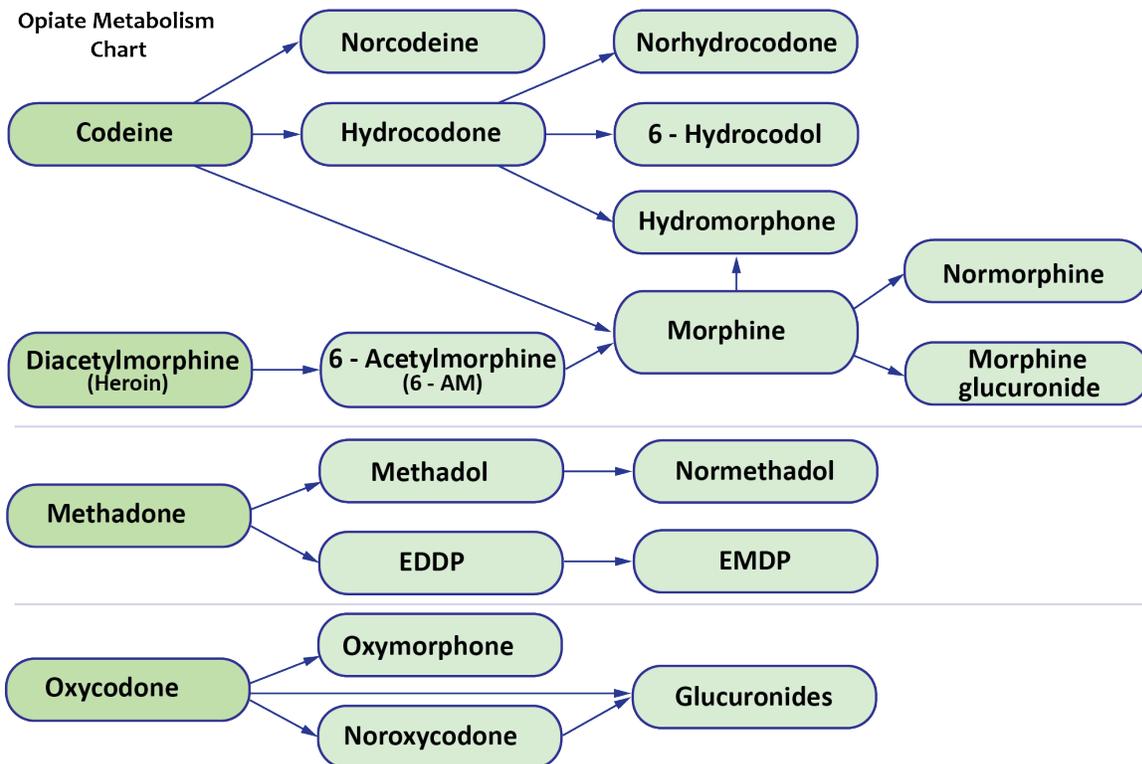
- Hand-washing facilities are made available to patient after provision of the sample
- Provide a dry collection area
- All sources of water should be disabled
- Bluing of toilet water

# Appendix S: Metabolism Charts

## Benzodiazepines



## Opioids



Stimulants (provided by the RRPL)

**Lisdexamfetamine (pro-drug)** - will exist and be detected as **amphetamine** in urine

**Amphetamine (Dexedrine), d-amphetamine (Adderall)** - will exist and be detected as **amphetamine** in urine

**Ritalin (methylphenidate), Dexmethylphenidate (Focalin)** – will exist and be detected as **methylphenidate** and / or **ritalinic acid** in urine

**Methamphetamine (Crystal Meth), d- methamphetamine** – will exist and be detected as **methamphetamine** and **amphetamine** (metabolite) in urine

**MDMA (methylenedioxymethamphetamine)** – will exist and be detected as **MDMA** and **MDA** (methylenedioxyamphetamine) in urine

**MDA (methylenedioxyamphetamine)** – will exist and be detected as **MDA in urine**

**MDEA (methylenedioxyethylamphetamine)** – will exist and be detected as **MDEA in urine**

## Appendix T: Take Home Dose Agreement

**Patient Name (or identification sticker):** \_\_\_\_\_

- I am aware that I am required to keep my medications in a lock box for safe storage
- I understand that carries will not be issued to me until I present proof (present the actual lockbox) to the pharmacist for him/her to see.
- I understand that being given carries is a privilege that is earned and that may be taken away if I violate my treatment agreement. Carries are the responsibility of the participant and will not be replaced if stolen, lost, spilled, or vomited.
- Regular carries on weekdays are only considered if there is a good reason to need them, such as work, school, volunteer, childcare responsibilities, or significant travel circumstances
- Weekday carries will not be given for the first three months of entry or reentry into the program, after release from prison, or loss of carries for any reason.
- Requests for carries on weekdays will not be considered if urine tests have not been free of illicit drugs for at least three months.
  - e.g. Requests for carries for a vacation will not be granted if drugs such as cocaine/morphine/Ativan (and other) are found on urine screens in the past three (3) months.
  - Exceptions may be made for true emergencies, though a case worker will have to verify the emergency before granting any carries.
- Requests for additional carries on weekdays require 48 hours' notice. Requests can be made in person at a regular scheduled visit or written on a form which is available at the front desk. A case worker may call you regarding this request.

_____	_____
Patient signature	Date
_____	
Witness Printed name	
_____	
_____	_____
Witness signature	Date

## Appendix U: Tapering Readiness Questions-Sample

When a patient indicates that he or she would like to leave treatment, several questions should be asked to determine if the person is ready to taper from OAT. Physicians should consider asking the patient the following questions:

1. Have you been abstaining from illegal drugs, such as cocaine and non-prescribed opioids and benzodiazepines?
2. Do you think you are able to cope with difficult situations without using drugs?
3. Are you employed or in school?
4. Are you staying away from people who use drugs and from illegal activities?
5. Have you got rid of your “works”/ “outfit”?
6. Are you living in a neighbourhood that doesn’t have a lot of drug use, and are you comfortable there?
7. Are you living in a stable family relationship?
8. Do you have non-drug-using friends that you spend time with?
9. Do you have friends or family who would be helpful during a taper?
10. Have you been participating in counselling that has been helpful?
11. Does your counsellor think you are ready to taper?
12. Do you think you would ask for help when you were feeling bad during a taper?
13. Have you been on OAT for a long time? (> 1 year)
14. Are you in good mental and physical health?
15. Do you want to get off OAT?

The more questions the patient can honestly answer in the affirmative, the greater the likelihood that he or she is ready to taper from OAT. Consider that each negative response represents an area that probably needs work to increase the odds of a successful taper.

*\*Adapted from “Tapering Readiness Inventory” from Treatment of Opiate Addiction with Methadone: A Counselor Manual, U.S. Department of Health and Human Services (DHHS) SMA94-2061. Reproduced in S. Brummett, R. Dumontet, L. Wermuth, M. Gold,*

*J.L. Sorensen, S. Batki, R. Dennis & R. Heaphy (1986), Methadone Maintenance to Abstinence: The Tapering Network Project Manual, University of California, San Francisco. Methadone Maintenance: A Counsellor’s Guide to Treatment, 24*

## Appendix V: Managed Opioid Withdrawal Using Slow-Release Oral Morphine During Methadone Induction

The purpose of managed opioid withdrawal during any induction is to:

1. Reduce IV drug use (IVDU) as quickly as possible, and
2. Engage the patient in ongoing care for their opioid use disorder (OUD)

Use of slow-release oral morphine (SROM) for Opioid Agonist Therapy (OAT) is **off-label** so very cautious assessment is required, along with patient consent and thorough documentation.

### *Risks & Benefits*

Methadone alone during induction may be insufficient in managing opioid withdrawal. It takes weeks to safely titrate methadone to a stable, therapeutic dose. During the induction phase, patients often struggle with withdrawal from their opioid IVDU. The desire to avoid withdrawal symptoms is often a stimulus for ongoing, problematic illicit use of uncertain quality and quantity until a sufficient blockade is established. Ongoing IVDU may disrupt the patient's engagement in recovery and ongoing OAT.

The risk of concurrent opioid (prescribed or illicit) use increases the risk of respiratory depression and overdose. With supplemental prescribed opioids, dosing must be conservative, and patients must be educated on the risks and management of potentially dangerous side effects.

### *Assessment*

A patient treated with any potential CNS depressant during methadone induction should have normal SaO<sub>2</sub> and no history, symptoms or clinical findings of respiratory compromise. Driving, work and/or care for children may be prohibited or discouraged due to the risk of increased sedation.

### *Dosing*

1. Determine the minimal daily amount of IV opioid required to avoid withdrawal. Convert dose into morphine equivalence (e.g. 1mg hydromorphone = 5mg morphine)
2. Divide by 2. This amount, given orally, is effectively 25% of the minimum IVDU requirement. Do not exceed 200mg per day.
3. Provide a slow-release oral morphine (SROM) preparation, daily witnessed with methadone.
4. **Taper** the SROM by 50mg per week, during the usual methadone induction process.
5. Monitor and manage adverse effects (e.g. excess sedation).

Note: The guideline (pg. 43) states, *Generally, patients should not be on other prescribed opioids during the initiation phase but if withdrawal symptoms indicate Kadian® may be prescribed in the induction phase for a maximum of 2 weeks. If the taper extends beyond 2 weeks, the reasons for not following the guideline must be justified and well documented.*

### ***Dosing Example***

JW used a range of 20mg to 24mg of hydromorphone IV, injected four times per day. His estimated minimal daily requirement was 20mg QID (80mg per day) which equates to 400mg of morphine equivalence.

JW was prescribed 200mg daily of Kadian® during his methadone induction, with tapering by 50mg per week. He reported cessation of IVDU within the first week of treatment.

## Appendix W: Buprenorphine/naloxone (Bup/nx) Microdosing

Some patients struggle with Bup/nx initiation because of precipitated withdrawal and the need to be opioid free to obtain an appropriate COWS score (>12-24 hours). Although considered **off-label**, Microdosing involves induction of small Bup/nx doses which is less likely to precipitate withdrawal.

### *Switching from methadone to Bup/nx*

Because of the high affinity for the  $\mu$  receptor, Bup accumulates at the receptor and bumps off the full  $\mu$  opioid agonist (e.g. methadone). There have been numerous microdosing protocols developed which have been based on case studies, making it difficult to determine the most effective protocol. Microdosing should be individualized and communication with the patient and care team is critical for success.

Day	Bup Dosing	Methadone Dosing
1	0.5 mg SL once daily	Full dose
2	0.5 mg SL twice daily	Full dose
3	1 mg SL twice daily	Full dose
4	2 mg SL twice daily	Full dose
5	4 mg SL twice daily	Full dose
6	8 mg SL once daily	Full dose
7	8 mg SL in AM and 4 mg SL in PM	Full dose
8	12 mg SL once daily	Stop

Reference: Terasaki D., et al. Transitioning Hospitalized Patients with Opioid Use Disorder from Methadone to Buprenorphine without a Period of Opioid Abstinence Using a Microdosing Protocol. *Pharmacotherapy* 2019;39(1): 1023-9.

Note: the above template may be utilized with any full opioid agonist. Patients may require a safe, pharmaceutical supply during Microdosing to avoid use of a contaminated supply.

## Appendix X: Table of Abbreviations

AA	Alcoholics Anonymous
Bup/Nx	Buprenorphine/naloxone
CAMH	Centre for Addiction and Mental Health
CBC	complete blood count
CBTPs	Correctional based temporary prescribers
CNS	central nervous system
COWS	Clinical Opiate Withdrawal Scale
CPSS	College of Physicians and Surgeons of Saskatchewan
CV	cardiovascular
DOB	date of birth
DSM-5	American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of mental disorders</i> (5th ed.). Washington, DC: Author.
ECG	electrocardiograms
GGT	gamma-glutamyl transpeptidase
GI	gastrointestinal
GU	genitourinary
HBV	Hepatitis B virus
HBTPs	Hospital based temporary prescribers
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IV	intravenous
LGBT2Q+	Lesbian, gay, bisexual, trans, sexually diverse
MCV	mean corpuscular volume
msec	millisecond
MMT	methadone maintenance treatment
NA	Narcotics Anonymous
NAS	Neonatal abstinence syndrome
NOWS	Neonatal opioid withdrawal syndrome
OAT	Opioid Agonist Therapy
OATP	Opiate Agonist Therapy Program
OOWS	Objective opioid withdrawal scale
ODD	Opioid use disorder
Pap	Papanicolaou test
PIP	Pharmaceutical information program
RUDS	Random urine drug screens
SOWS	Subjective opioid withdrawal scale

THC	Tetrahydrocannabinol
TID	"ter in die", three times a day
UDS	Urine Drug Screen

## Appendix Y: Glossary

### **Abuse, drug**

Any use of an illegal drug, or the intentional self-administration of a medication for a non-medical purpose such as altering one's state of consciousness, e.g., "getting high." (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

### **Addiction**

A primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

### **Agonist**

1. Drugs that interact with receptor sites to cause the same effect that natural chemicals would cause at these sites. (Karch, A, M. (2008). *Focus on nursing in pharmacology*. (4th ed.). Philadelphia: Wolters Kluwer/ Lippincott Williams & Wilkins). **2.** A substance that acts at a neuronal receptor to produce effects like those of a reference psychoactive substance, e.g. methadone is an agonist at the opioid receptors.

### **Antagonist**

1. Drugs that combine with receptors that do not begin a change in cell function. When antagonists bind to receptors, agonists are prevented from binding and causing an action. Gutierrez, K. (2008). *Pharmacotherapeutics: Clinical reasoning in primary care* (2nd ed.). Saunders: St. Louis. **2.** (Adopted Canadian Society of Addiction Medicine October 14, 1999) A substance that counteracts the effects of a reference psychoactive substance by inhibiting or reversing its effects at a neuronal receptor site, e.g. naltrexone acts as an antagonist at the opioid receptor.

### **Concurrent Disorders** – (Adopted Canadian Society of Addiction Medicine October 14, 1999)

The presence of one or more primary, physical and/or psychiatric disorders that have an interactive effect on the course of Substance Dependence and require specific diagnosis and treatment to achieve stabilization and/or recovery.

### **Craving** – (Adopted Canadian Society of Addiction Medicine October 14, 1999)

A bio-psychological arousal and urge to return to addictive behaviour, characterized by a strong desire, pre-occupation and possible impulsivity.

## Dependence, Physical

A state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## Diversio<sup>15</sup>

Any non-intended or non-medical use of a prescribed opioid (including prescribed opioid agonist medication) or use by any individual other than the individual for whom it was prescribed.

## Dose, stable

A “pharmacologically stable dose” is one that produces a fairly steady plasma level; it is established when the total daily dose is fixed for at least two weeks and:

1. frequency is scheduled and spread throughout the day, AND/OR
2. at least 70% of the prescribed opioid is controlled release.

## Half-life

The time required for half of the total drug amount to be eliminated from the body. Generally, after five half-lives, 97% of a drug will be eliminated.

## Pharmacotherapeutics for Advanced Practice

*A Practical Approach*, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006.

## Harm Reduction

A continuum of services that represent a philosophical, pragmatic approach to providing care while minimizing the negative outcomes associated with substance use. The focus is goal oriented, humanistic and in keeping with a cost benefit awareness. (Pauly, Goldstone, McCall, Gold & Pyne, 2007). Pauly, B., Goldstone, I., McCall, J., Gold, F., & Payne, S. (2007). *The ethical, legal and social context of harm reductions*. *Canadian Nurse*, 103, 19–23.

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<sup>15</sup> Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. (p. 51) Retrieved from [https://crism.ca/wp-content/uploads/2018/03/CRISM\\_NationalGuideline\\_OUD-ENG.pdf](https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf)

## **Maintenance Therapy**

Treatment of Substance Dependence by a prescription drug, to prevent withdrawal and reduce the harm associated with a particular method of administration, attendant dangers to health and/or social consequences, e.g. methadone for Opioid Dependence or nicotine replacement therapy (NRT) for tobacco.

## **Methadone Toxicity**

When the level of methadone in the body exceeds the level that is determined safe.

## **Misuse, opioid**

Use of an opioid in ways other than those intended by the prescribing physician (sometimes also called problematic opioid use). (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## **Narcotic**

Any drug included in the “Schedule” under the *Controlled Drugs and Substances Act: Narcotic Control Regulations*. (Ministry of Justice)

## **Opiate**

A naturally occurring or semi-synthetic compound derived from the opium poppy (*papaver somnifer*) (College of Physicians and Surgeons of Alberta, 2005).

## **Opioid**

A compound having actions or properties similar to opiates. A broader term encompassing all opiates (such as heroin, morphine and codeine) as well as synthetic opiate-like compounds (such as methadone and fentanyl). (College of Physicians and Surgeons of Alberta, 2005).

A family of drugs that act by attaching to endogenous mu, kappa and delta receptors in the brain and share a common set of clinical effects, including analgesia, sedation, constipation, and respiratory depression.

*Note: Reference throughout this document to specific pharmaceutical products as examples does not imply endorsement of any of these products.*

## Opioid agonist treatment (OAT)<sup>16</sup>

Opioid agonist medications prescribed for the treatment of opioid use disorder. OAT is typically provided in conjunction with provider-led counselling; long-term substance-use monitoring (e.g. regular assessment, follow-up, and urine drug tests); comprehensive preventive and primary care; and referrals to psychosocial treatment interventions, psychosocial supports, and specialist care as required. “Opioid agonist treatment (OAT) is the preferred terminology, representing an intentional shift from the use of opioid substitution treatment (OST), opioid maintenance treatment (OMT) and opioid replacement therapy (ORT).

## Pharmacodynamics

The set of processes by which drugs produce specific biochemical or physiological changes in the body-how the drug acts on the body. *Pharmacotherapeutics for Advanced Practice – A Practical Approach*, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006 (Arcangelo & Peterson, 2006).

## Pharmacokinetics

Examining the absorption, distribution, metabolism and excretion of a drug, the onset of action, the half-life, peak effect and duration of effects – how the body acts on the drug. Karch, A, M. (2008). *Focus on nursing in pharmacology*. (4th ed.). Philadelphia: Wolters Kluwer/ Lippincott Williams & Wilkins.

## Precipitated withdrawal<sup>17</sup>

A withdrawal syndrome that can occur when an opioid antagonist or partial agonist, such as buprenorphine, is administered to a patient who is physically dependent and has recently used to a full opioid agonist. Due to buprenorphine’s high affinity but low intrinsic activity at the mu (u) receptor, the partial agonist displaces full agonist opioids from the mu (u) receptors, without activating the receptor to an equivalent degree, resulting in a net decrease in effect. Precipitate withdrawal is more intense and has a much faster onset than typical withdrawal from opioids.

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<sup>16</sup> Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. (p. 55) Retrieved from [https://crism.ca/wp-content/uploads/2018/03/CRISM\\_NationalGuideline\\_OUD-ENG.pdf](https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf)

<sup>17</sup> Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. (p. 55) Retrieved from [https://crism.ca/wp-content/uploads/2018/03/CRISM\\_NationalGuideline\\_OUD-ENG.pdf](https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf)

## Split doses

An alternative way of providing methadone to clients, consisting of two or more doses per day (so it is not ingested all at one time). It is used for clients who have demonstrated “rapid metabolism” of their once daily methadone dose (e.g. during third trimester of pregnancy) or are on medications that have been shown to induce rapid metabolism of methadone (i.e. certain HIV medications). A consultation with an experienced MMT provider should be considered in these circumstances. Split doses do not necessarily have to be equal; twice- daily observed ingestion may be necessary (College of Physicians and Surgeons of Alberta, 2005)

## Stable daily dose

Optimal daily dose of methadone that will relieve withdrawal symptoms, block opioid-induced euphoria and reduce drug cravings without sedation or other significant side effects (College of Physicians and Surgeons Ontario, 2005).

## Steady state

A constant mean concentration of a drug in the body, there are peaks and troughs in the drug level, but the fluctuations remain within a constant range. *Pharmacotherapeutics for Advanced Practice – A Practical Approach*, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006. (Arcangelo & Peterson, 2006).

## Substance

Any drug with pleasant psychoactive effects and addiction potential, including alcohol, illegal drugs, and prescription drugs. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## Substance abuse – (American Psychiatric Association, 1994)

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
  - a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
  - b. recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).
  - c. recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)

2. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)
  - a. The symptoms have never met the criteria of Substance Dependence for this class of substance.

### **Substance dependence**

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period (American Psychiatric Association, 1994)

1. *Tolerance*, as defined by either of the following:
  - a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect; or
  - b. markedly diminished effect with continued use of the same amount of the substance.
  
2. *Withdrawal*, as manifested by either of the following:
  - a. the characteristic withdrawal syndrome for the substance; or
  - b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
  
3. The substance is often taken in larger amounts or over a longer period than was intended.
  
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
  
5. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects.
  
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

With physiological dependence: evidence of tolerance or withdrawal (i.e. either Item 1 or 2 is present).

Without physiological dependence: no evidence of tolerance or withdrawal (i.e. neither Item 1 nor 2 is present).

### **Substance misuse**

The use of a psychoactive substance (drug or alcohol) for a purpose other than that for which it was intended, and that cause's physical, social, and psychological harm. The term is also used to represent the pattern of use: experimental, recreational, and dependent (Rassool, 2002). *Substance misuse and mental health: An Overview*. Nursing Standard, 16, 46-52.

### **Substance tolerance**

A neurological adaptation to the psychoactive effects of a substance; more of the drug is required to achieve the same effect. Tolerance develops quickly to the psychoactive effects of alcohol and opioids. Highly tolerant clients can behave almost normally after consuming opioid doses that would be fatal in non-tolerant clients (Kahan & Wilson, 2002). Tolerance to the psychoactive effects of opioids develops within days, and is lost within days (CPSO, 2005). A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more opioid effects over time. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010) Substance Use Disorders (Adopted Canadian Society of Addiction Medicine October 17, 2003) A category of two disorders, namely, Substance Abuse and Substance Dependence, as in DSM IV.

### **Substance withdrawal**

Characteristic syndrome produced by abrupt cessation of a drug. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

### **Tapering**

A gradual decrease in a dose of a drug; could result in a lower daily dose or cessation of the drug. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

## Titration

A technique of adjusting a dose until a stable/ optimal dose is reached; usually means gradually increasing the dose to allow the body to develop tolerance and minimize adverse effects. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## Tolerance

A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more opioid effects over time. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## Withdrawal

Characteristic syndrome produced by abrupt cessation of a drug. (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010*)

## Withdrawal management<sup>18</sup>

The use of pharmacological treatment (e.g. opioid agonist tapers, alpha2-adrenergic agonists) to mitigate withdrawal symptoms and withdrawal-related adverse events when an individual stops using opioids in pursuits of abstinence. This terminology represents a deliberate shift away from the use of “detox” or “detoxification” to refer to medically supervised withdrawal from substances.

**Slow taper:** gradual dose reduction of opioid agonist medication, typically in an outpatient or residential setting over a month (or longer) period

**Rapid taper:** Rapid dose reduction of opioid agonist medication, typically in a hospital or dedicated inpatient withdrawal management facility over a period of one week or less.

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<sup>18</sup> Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. (p. 51) Retrieved from [https://crism.ca/wp-content/uploads/2018/03/CRISM\\_NationalGuideline\\_OUD-ENG.pdf](https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf)

## Endnotes

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- <sup>1</sup> British Columbia Ministry of Health. (2018). *Opioid Use Disorder: Diagnosis and Management in Primary Care*. (p. 2) Retrieved from <https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/opioid-use-disorder.pdf>
- <sup>2</sup> Stigma and discrimination. (n.d.). Retrieved from <http://www.catie.ca/en/hiv-canada/4/4-1/4-1-1>
- <sup>3</sup> Stigma. (n.d.). Retrieved from <https://www.camh.ca/en/health-info/guides-and-publications/stigma>
- <sup>4</sup> How You Can Fight the Stigma of Addiction (And Why It Matters). (n.d.). Retrieved from <https://www.addictions.com/prescription-drugs/how-you-can-fight-the-stigma-of-addiction-and-why-it-matters/>
- <sup>5</sup> Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. (p. 36/37) Retrieved from [https://crism.ca/wp-content/uploads/2018/03/CRISM\\_NationalGuideline\\_OUD-ENG.pdf](https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf)
- <sup>6</sup> Ibid.
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