OAT in Hospital During the COVID-19 Pandemic

During the COVID-19 pandemic, physicians assisting in hospitals and facilities will likely care for any number of our over 4,000 Saskatchewan patients currently being treated with opioid agonist therapy (e.g. methadone or buprenorphine/naloxone) for opioid use disorder (OUD). Clinical judgment is always essential, but it can be challenging to exercise clinical judgment in critical care settings with minimal or no experience with OAT.

The aim of this document is to provide you with some regulatory and basic clinical guidance for treating patients with opioid use disorder in hospital. It is by no means exhaustive, so you are always encouraged to contact an experienced OAT provider, consult with in-house professionals and/or speak with the Opioid Agonist Therapy Program regarding specific patient concerns.

Hospital-Based Temporary Prescribers (HBTPs)

This applies to physicians who do not prescribe OAT as part of their practice but may, for a brief period, prescribe methadone or buprenorphine/naloxone for the treatment of opioid use disorder to a patient in hospital. If a physician is not a patient's current OAT prescriber, he/she 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.

Key Points for HBTPs

- Confirm the last dose and time of last dose and aim to maintain OAT, at some level, unless contraindicated or a re-start is required due to missed doses
- If medically necessary, the dose may be held (if held >24 hours, contact the community prescriber/authorized OAT provider prior to re-initiation); in an urgent or emergent situation (e.g. ICU admission), the dose may be decreased
- **Communicate with the patient's community OAT provider**
- If the patient's OAT provider is unavailable, collaborate with another experienced OAT provider
- Additional analgesia is typically required for acute pain, even if the patient is on OAT
- Ensure access to ongoing OAT care on discharge (including an OAT prescription)
- Avoid punitive measures

Additional Safety Measures

- Refer patients with OUD for OAT initiation by an OAT provider, if possible
- For patients on methadone therapy, be cautious when initiating other medications with potential for QTc prolongation, CNS depression and/or serotonergic effects – consult with a pharmacist if you are able to

- Ensure a naloxone PRN order is available, especially when ordering additional opioids for pain control
- Exercise caution if considering initiation of benzodiazepines for patients on OAT; use alternatives unless absolutely necessary
- Consider screening for HCV, HIV and STIs in the appropriate context
- Provide patients with a Take Home Naloxone kit on discharge and counsel on harm reduction strategies and public health recommendations related to COVID-19

Advise of Harm Reduction Strategies

- Never use alone but also minimize contact with others
- Always have access to Take Home Naloxone
- Do not inject
- Do not share or reuse paraphernalia/supplies (cigarettes, needles, utensils, etc.)
    - If sharing is a must, be sure to clean mouthpieces and equipment with alcohol
- If using non-prescription sources, take a small test dose
- Keep surfaces clean when preparing drugs
- Do not mix opioids with other medications (e.g. Gravol, benzodiazepines, alcohol, etc.)

COVID-19 Disease-Related Concerns[1]

Always consult with an experienced OAT provider and a pharmacist, if available

- **Impaired consciousness/coma**: use with caution and monitor; if medically necessary, the dose may be held or decreased in an urgent or emergent situation
    - Patients may susceptible to intracranial effects of CO_2 retention
- **Respiratory disease**: use with caution and monitor; if medically necessary, the dose may be held or decreased in an urgent or emergent situation
    - Respiratory depression may occur even at therapeutic doses
- **QTc prolongation (methadone)**: use with caution and monitor especially with risk factors (e.g. cardiac hypertrophy, diuretic use, hypokalemia, hypomagnesemia), a cardiac history and concurrent use of other medications impacting QT interval
    - More common with higher doses of methadone
- **Hepatic impairment**: buprenorphine/naloxone use is not recommended with severe impairment; use with caution and monitor with moderate impairment for buprenorphine/naloxone and methadone
    - Reduced clearance of naloxone and potential for reduced buprenorphine efficacy
- **Renal impairment**: use with caution and monitor
    - Dose adjustments for methadone are not usually required when CrCl ≥10 mL/minute

Lexicomp Online, Lexi-Drugs Online, Hudson, Ohio: Wolters Kluwer Clinical Drug Information, Inc.; 2020; Apr 1 2020.

Standard (CPSS Standards & Guidelines for the Treatment of OUD)

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

HBTPs, licensed to practice medicine in Saskatchewan, are permitted to prescribe methadone or buprenorphine/naloxone to patients in a hospital setting without obtaining approval from the CPSS Registrar if the following terms and conditions are met:

a) For inpatients: the patient must currently be receiving methadone or buprenorphine/naloxone treatment prior to hospitalization (or admission to an equivalent acute care facility in rural centres).

-For patients seen in the Emergency Room: the patient must currently be receiving methadone or buprenorphine/naloxone 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 methadone or buprenorphine/naloxone 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 both the daily dose and date/time of last administration of the methadone or buprenorphine/naloxone from a reliable source (e.g. from the patient if appropriate or 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 dose. If medically necessary, the dose may be held – **if** the dose is held for >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 methadone;

vi. Only prescribe methadone or buprenorphine/naloxone for the management of opioid use disorder;

vii. 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 methadone or buprenorphine/naloxone prescriptions when the patient leaves the hospital (or equivalent acute care facility in rural centres) or the Emergency Room.

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.

Prescribing carried doses is not permitted (i.e. all doses provided must be witnessed), except in consultation with the community-based prescriber.

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,

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

Nothing in this section applies to a prescriber 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.

Helpful Resources

College of Physicians and Surgeons of Saskatchewan: Standards and Guidelines for the Treatment of Opioid Use Disorder

Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline (Centre for Addiction and Mental Health)

Harm Reduction Coalition: Safer Drug Use During the COVID-19 Outbreak

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