nova scotia health
Mental Health and Addictions Program

Prescribing Opioid Agonist Therapy in MHAP Opioid Recovery Program

Section 1: Buprenorphine Guidelines

Developed by:
NS Health Prescribing OAT Expert Panel

July 2024

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

We respectfully recognize that we are living and working in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People. We strive to deeply understand that this land is treaty land. Mi'kma'ki is governed by the Peace and Friendship Treaties, which were signed as a shared commitment to peace, friendship, cooperation, and respect. We are all responsible for honouring the Peace and Friendship Treaties.

We acknowledge that colonialism, broken promises and repeated violation of these treaties have caused, and continue to cause, harms for Indigenous people, leaving unmistakable marks upon the Mi'kmaq People. The Mental Health and Addictions Program (MHAP) commits to truth and reconciliation, recognizing the impact of ongoing harms on mental wellbeing and overall health outcomes. We are working to incorporate this understanding into the treatment and care we offer to Indigenous clients, and in our relationships with First Nations Communities, through learning, growing and changing.

We also acknowledge the histories, contributions, and legacies of the African Nova Scotian people and communities who have been here for over 400 years.

We recognize that the ongoing criminalization, institutionalization, and discrimination against people who use drugs disproportionately harm Black, Indigenous and Racialized (BIR) individuals and communities, and that continuous efforts are needed to dismantle colonial systems of oppression.

We thank our clients and their families who teach us invaluable lessons about the art and practice of addiction medicine. We hope this guidance document helps to reduce the harms faced by people who use drugs and for those working toward recovery.

CONTRIBUTORS

These guidelines were developed through the collective effort of many dedicated and knowledgeable people. Nova Scotia Health would like to acknowledge and thank everyone involved in the process, including those who guided the ORP Provincial Practice Project, participated in the Prescribing OAT discussion series, submitted feedback on evidence review, reviewed and provided feedback on the draft document, and/or contributed to the evaluation of this work.

In particular, we thank participants in the Prescribing OAT Discussion Series, whose keen insights, honest questions, and rich dialogue informed the development of these guidelines. This group includes physicians, nurse practitioners, pharmacists, ORP managers, team leaders, clinical nurse educators, Interprofessional Practice and Learning, and people with lived or living experience with OUD treatment:

Sarah Burgess
Muna Chowdhury
Seneca ClassenPottie
Melissa Dakai
Victoria Dixon
Carley Gilby
Leisha Hawker
Sam Hickcox
Alex Hosein
Marisa Janes
Julie Kaplan
Sian Lanthier
Heather Lohnes
Lynn Lowe
Lynn MacNeil
David Martell
Paula Martin
Bob Mullan
Elizabeth Munn
Trevor Russell
Thomas Veinot
Malorie Weir

BACKGROUND

Mental Health and Addictions Program (MHAP) is working to improve access to evidence-informed care for people living with Opioid Use Disorder (OUD) across Nova Scotia (NS). As one component of this improvement process, MHAP is establishing provincial guidelines for the primary Opioid Agonist Therapy (OAT) medications at Opioid Recovery Program (ORP) clinics across NS.

Evidence-informed care for OUD is evolving rapidly. With the retirement of the *College of Physicians and Surgeons of Nova Scotia: Methadone Maintenance Treatment Handbook* in 2017, MHAP ORP healthcare providers who support people living with OUD did not have up to date guidance on evidence-informed treatment that was easy to access and adapted to the NS environment.

The MHAP *Prescribing Opioid Agonist Therapy: Section 1 Buprenorphine Guidelines* is the first of several iterations in development that synthesize recent evidence-based practice for OUD to enable a practical approach to treatment decision-making and care. This guideline was developed through a rigorous process which included the review of evidence-based documents and resources (see References) by a NS OAT expert panel (e.g. ORP managers, staff and physicians; pharmacists; community partner representatives), who participated in four (4) 90-minute virtual discussion sessions between November 2023 and January 2024 to inform the development of the guidelines.

This guideline is intended to inform treatment and practice within Nova Scotia Health Opioid Recovery Program (ORP) settings. Evidence-based care for people living with opioid use disorder ensures that treatment is tailored to the individual needs of patients. This guideline will inform clinical decision-making in collaboration with a patient's individual needs, preferences, and values. This guideline will be reviewed and updated as evidence and practice evolve.

INTRODUCTION TO NS HEALTH PRESCRIBING OAT GUIDELINES

These guidelines:

- Were developed as part of NS Health's *ORP Provincial Practice Project*. Grounded in evidence and emerging best practices, the project aims to improve consistent ORP practices across Nova Scotia so that clients throughout the province can expect the same level of high-quality, safe and sustainable care for OUD.

- Align with the guiding principles of the ORP provincial practice project:
    - Offer flexible, individualized, trauma-informed, and harm reducing care.
    - Take a collaborative and evidence-informed approach.
    - Value and respect all voices and co-create safe spaces.
    - Advocate and educate to eliminate stigma and discrimination.

- Are based upon the most current evidence available at time of writing and supported by practitioner expertise. A comprehensive list of resources is included at the end of this document.

- Are intended to serve as a resource to guide decision-making for prescribers and teams supporting the provision of OAT in Mental Health and Addictions Program's (MHAP) provincial Opioid Recovery Program (ORP).

- Provide easy access to evidenced-informed approaches for the clinical management of Opioid Use Disorder (OUD) for NS Health staff and prescribers involved in the care and management of individuals, families and communities affected by opioid use.

- Are a collection of agreed upon practice norms intended to supplement existing standards and guidelines. The Guidelines are not meant to supersede clinical experience or decision-making specific to an assessment of a client's clinical stability and circumstances. Individualized, flexible, client-centred care is paramount.

- Comprise an iterative, 'living document' that will evolve with the evidence. As new research and clinical experience broaden our knowledge, treatment recommendations may change.

As of May 2024, this guide is focused on buprenorphine-naloxone. Sections on methadone and slow-release oral morphine (SROM) will be added later in 2024.

Language

Language is an evolution where preferred terms ebb and flow over time. These guidelines aim to use language related to substance use that is compassionate and respects the dignity of individuals. Further, the guidelines invite readers to consider the impact of language and be vigilant about working towards eliminating stigma in health care.

For the purposes of this document, the contributors had in-depth discussions around language and agreed to the following:

Patient /client are terms used interchangeably. Both are broadly used within MHAP and most clinical settings.

Individualized OAT treatment is preferred, shifting away from language that previously ranked OAT medications as first-line, second line, and third-line options. It is recommended that clinicians discuss with patients the risks and benefits of three OAT options and collaboratively select a medication most suitable for that individual.

Dispensing Frequency is the preferred term over 'take-home dosing', especially in the context of bup/nlx, which is dispensed with the same approach as any medication to manage chronic illness.

Initiation is the preferred word choice over 'induction'. Initiation implies the beginning of something new. Induction is often something that is done 'to' someone.

Ongoing OAT is the preferred language choice over the previously used 'maintenance phase'. There are no phases in opioid treatment. OAT is ongoing and fluid.

No brand names are used in these guidelines. Medications are referred to generically. ORP team and OAT providers are encouraged to avoid brand names where possible.

Long-acting injectable buprenorphine (LAIB) is the preferred language choice over extended-release subcutaneous buprenorphine injection or brand name.

OAT CARE PRINCIPLES

When an individual is registered as a client of the Opioid Recovery Program (ORP), prescribers will work with each patient to determine which OAT medication is most appropriate for the individual based on:

- the patient's circumstances,
- goals,
- previous treatment experiences.

OAT is a longitudinal treatment and continuity of care is critical. Ongoing follow up with ORP is a program requirement. Psychosocial aspects of care and other supports are to be offered as part of the treatment plan when initiating pharmacotherapy.

Three OAT options may be considered**:

- Buprenorphine/naloxone (bup/nlx).
  - Long-acting injectable buprenorphine (LAIB) may be an option.
- Methadone.
- Slow-release oral morphine (SROM).

Different opioids have different QTc prolongation risk.

Morphine and bup/nlx have low risk; oxycodone, fentanyl and tramadol have intermediate risk; methadone has high risk.

****Avoid withdrawal management as a stand-alone treatment.**

See **Appendix A** for Decision Support Tool for Selecting OAT.

During local or global emergencies and disruptions, patient care is to be adapted, as needed, to ensure patients can continue to access treatment for Opioid Use Disorder (OUD) without unreasonable barriers. Adaptations may include extended dispensing frequency, increased unwitnessed/unobserved doses, reduced urine drug testing, reduced clinic appointments / virtual care, facilitating transfer of prescriptions to a new pharmacy, or engaging other health care providers to support medication management.

OAT PRESCRIPTIONS

Prescriptions for OAT must be clear and complete. See **Appendix B** for sample script. Pharmacy practitioners must be provided with or have access to the following information:

- Drug and form (i.e., tab or film)
- Dose (total daily dose)
- Duration (include total quantity in milligrams or tablets for the entire duration of prescription)
- Directions (i.e., witness / DWI) *
- Frequency (i.e., once daily)
- Dispensing schedule, including:
  - the start and end date of the prescription **
  - the number of dispensed doses per week and schedule for observed ingestion (if applicable)
  - the days of the week that require witnessed or observed ingestion (if applicable)
- Any requirement for compliance packaging.

* A prescription for bup/nlx, written with directions for witnessed ingestion, does not require the patient to remain under supervision until the medication has dissolved. The patient may leave the pharmacy once a pharmacy team member has directly observed the self-administration of the dose, **unless specifically indicated on the prescription** that the patient is to remain under observation until the medication has dissolved, or "Pt stays until dissolved".

** Regardless of whether there are any authorized doses remaining, a prescription cannot be dispensed after its end date. Pharmacists are required to notify the prescriber when prescriptions are extended beyond the end date. If a pharmacist extends a prescription past the end date, the prescriber will be notified without delay.

PHARMACOTHERAPY FOR SYMPTOMATIC TREATMENT OF OPIOID WITHDRAWAL

For treatment of withdrawal symptoms, consider:

TABLE 1

Symptoms	Medication	Dosage
Agitation, excessive sympathetic overdrive (e.g., anxiety, agitation tachycardia, and tremor)	Clonidine	0.1–0.2mg PO PRN every 4-6 hours (for <12 hours for precipitated withdrawal)
Insomnia	Trazodone	50mg PO QHS PRN
Nausea	Dimenhydrinate	50–100mg PO Q6H PRN
Pain	Acetaminophen	325–1000mg PO PRN every 4-6 hours (maximum 4000mg day; 2000mg for older adults or those with liver impairment)
	NSAIDS (e.g., Ibuprofen)	400mg PO PRN every 8 hours
Diarrhea	Loperamide	2–4mg PRN (maximum 16mg day)
Don't prescribe benzodiazepines for opioid withdrawal symptoms.		

BUPRENORPHINE-NALOXONE

Introduction

In the absence of contraindications, buprenorphine/naloxone (bup/nlx) is broadly recommended as the preferred OAT option. Current evidence identifies bup/nlx as having a more favorable safety profile for most clients with Opioid Use Disorder (OUD); however, the clinical decision to transition to, or away from, bup/nlx must be shared with clients and balanced with the risks involved given the individual's situation. Clinicians will use an individualized and stepwise approach in order to determine the optimal dose for each patient. For individuals who do not stabilize with bup/nlx, or prefer another type of OAT, care providers will consult with client to consider whether methadone or slow-release oral morphine (SROM) might be more suitable.

Selecting bup/nlx as the preferred treatment approach is suitable for most individuals that:

- have been diagnosed with moderate to severe opioid use disorder,
- have no contraindications,
- have received information about all the options and given their informed consent.

Benefits

- Relative to methadone and other opioids, buprenorphine has a more favorable safety profile including lower risk of overdose, especially when combined with alcohol and benzodiazepines.
- Favourable side effect profile.
- Lower risk of QTc prolongation.
- Increased flexibility with dispensing intervals.
- Shorter time to achieve therapeutic doses.
- Fewer drug-drug interactions.

For risks, side effects and adverse reactions, see **Appendix A**.

Buprenorphine Formulations Available in Nova Scotia

- Tablets: Buprenorphine/naloxone 2/0.5mg, 8/2mg, 12/3mg and 16/4mg SL.
  - Tablets MUST be taken sublingually; they are not effective when swallowed due to first-pass effect.
  - Tablets can be split, if necessary, or combined to make the required/requested dose.

- Film: Buprenorphine/naloxone 2/0.5mg, 4/1mg, 8/2mg, and 12/3mg SL or buccal.
  - Buccal film should not be subdivided

- Injectable prefilled syringes: Long-acting injectable buprenorphine 300mg/1.5ml and 100mg/0.5ml.
  - The increased volume may increase discomfort for some individuals upon administration.

Evidence suggests no significant differences in dose effects, adverse effects, or treatment outcomes between bup/nlx film and sublingual tablets. Some patients may prefer the taste or faster dissolving time of the film compared to the sublingual tablet.

Bup/nlx film and SL tablet are not bioequivalent at all doses and routes of administration. Because some strengths of bup/nlx film produces higher bioavailability compared to the same dose of the sublingual tablet, switching between the two forms could theoretically lead to inadvertent over- or under-dosing. Switching between formulations will be done only with appropriate monitoring for symptoms of over- or under-dosing of buprenorphine. Due to greater bioavailability when dosing buccally, initial film(s) should be administered sublingually.

Consult the product monograph for further information on routes of administration.

Long-Acting Injectable Buprenorphine (LAIB)

Long-Acting Injectable Buprenorphine (also known as extended-release buprenorphine) – administered monthly (26-42 days between doses) via abdominal subcutaneous injection – is indicated for individuals who have been clinically stabilized on a minimum of 8mg of sublingual bup/nlx, ideally for a minimum of seven days. Ongoing substance use will not interfere with initiating on LAIB.

Discuss potential risks and benefits, obtain informed consent, and schedule regular follow-up including monitoring for cravings and withdrawal symptoms following initiation of LAIB.

Initial monthly doses of 300mg for two months, typically followed by monthly doses of 100mg. Some individuals require a maintenance dose of 300mg.

Ensure buprenorphine sustained release injection is dispensed and/or administered in accordance with the manufacturer requirements and **not dispensed directly to the patient.** In practice, this may look like pharmacy delivering to the clinic or staff from clinic picking up. Also, some pharmacists are trained and set up to offer injections.

You may consider discussing switching to LAIB if the patient also:

- Requires less frequent medication administration (i.e., fewer trips to pharmacy).
- Is comfortable with a subcutaneous injection.
- Does not want to administer medications sublingually.
- Has drug coverage or is able to cover the cost of medication.

INITIATING OAT WITH BUPRENORPHINE-NALOXONE (BUP/NLX)

Precipitated Withdrawal

The unique pharmacology of bup/nlx can lead to a risk of precipitated withdrawal when initiating the medication. Precipitated withdrawal is a state of severe and acute withdrawal that can occur if the initial dose of buprenorphine is given when a client still has other opioids active on the receptor. As buprenorphine is a partial opioid agonist with high affinity, it displaces other opioids but does not fully replace their effect, leaving the patient with a net opioid deficit.

If precipitated withdrawal occurs, withdrawal symptoms will appear as early as 15 to 60 minutes after taking bup/nlx. This may discourage a patient who is new to buprenorphine from continuing with treatment, so it is imperative to take preventative and supportive measures (**see Table 1, page 9**).

To reduce the risk of precipitated withdrawal, provide a sufficient time lapse from the last use of opioids. Traditional initiation doses of bup/nlx require the patient to be in at least moderate opioid withdrawal prior to the first dose. If the individual is unable, or prefers not, to experience withdrawal, consider micro-dosing. *Apply extra caution and guidance when initiating treatment for people who are taking methadone or are fentanyl tolerant*.

To avoid precipitated withdrawal, the Clinical Opiate Withdrawal Scale (COWS) is a tool used to assist in this determination. The timing of the last reported use of opioids can be useful in determining whether it is safe to proceed. If client is in moderate withdrawal (COWS≥12), initiation of treatment can usually be considered. (See **Table 2, page 13**).

Initiation Setting

Before commencing bup/nlx, consider the preferred setting(s) in which to initiate dosing, and strategies to reduce the risk of precipitated withdrawal. OAT prescribers will explore the practical advantages and disadvantages of each protocol with patients to find the best fit for them. There are several options for initiating OAT with bup/nlx, each addressed with more information below:

1.Pharmacy or clinic start: First dose is usually administered at the pharmacy when the patient is in withdrawal; subsequent doses are taken as required on the same day, either in the same location or by the patient at home.

2. Home start: Patient is given a prescription to start at home.

3.Micro-dosing: For patients who cannot stop opioids long enough to avoid precipitated withdrawal and for patients who prefer to avoid moderate withdrawal, regardless of what opioid(s) they use.

4.Macro-dosing: For patients who are fentanyl tolerant.

5.Rotating methadone to bup/nlx: Some patients who show a successful and sustained response to methadone may wish to transition to bup/nlx.

1. Pharmacy/Clinic Start

Traditional pharmacy or clinic initiation protocols require a period of abstinence from opioids prior to initiation, in order to prevent precipitated withdrawal. If client is opioid tolerant, willing and able to experience moderate withdrawal before initiating bup/nlx (COWS≥12) and has had adequate time since last opioid use to prevent precipitated withdrawal (see Table 2 below), they may be suitable for traditional pharmacy or clinic initiation.

This may not be the preferred option for patients who currently use fentanyl or other intermediate- and long-acting opioids (e.g., methadone) that require longer periods of pre-initiation withdrawal, which can be both time-consuming and difficult for patients. If client is unable, or prefers not to experience withdrawal, consider micro-dosing. Prescribers should discuss the risks and benefits of all initiation options with patients and support informed decision-making. For more information on micro-dosing, see page 16.

TABLE 2

In general, the duration of time between last opioid dose and onset of moderate withdrawal (COWS score ≥12) is as follows:		
Short-acting opioids	≥ 12 Hours	Examples: Heroin, morphine, hydrocodone, immediate-release oxycodone
Intermediate-acting opioids	≥ 24 Hours	Examples: Slow-release oral morphine (SROM), sustained-release hydromorphone, sustained-release oxycodone
Long-acting opioids	48-72 hours and/or seek advice*	Examples: Methadone or fentanyl
The **Addiction Medicine Consult Service (AMCS) is available Monday to Friday 8:30 a.m. to 4:30 p.m., offering rapid telephone advice to physicians, pharmacists and nurse practitioners: **1-855-970-0234**.*		

CAMH (2021) offers the following recommendations for pharmacy initiation:

- Prescribe 2–4 mg of bup/nlx as an initial supervised dose when the patient is in moderate to severe withdrawal (COWS ≥ 12).
- Up to 6 mg is acceptable in clinically required situations, and may increase the risk of precipitating withdrawal.

- Reassess the patient after one to three hours and prescribe additional observed doses if necessary (e.g., COWS > 8, symptoms of withdrawal).
    - Be careful not to precipitate withdrawal by giving too high a dose or by medicating in the absence of observable withdrawal.
    - One or two 2 mg tablets to take home may be provided if repeated observation is not feasible in the clinical setting, with clear instructions on timing the dose to avoid precipitating withdrawal.
- Avoid prescribing more than 12 mg bup/nlx total on the first day.

While it is safe to titrate bup/nlx daily, the full clinical effect will take longer to achieve. At a constant daily dose, the serum level of buprenorphine rises over time (bioaccumulation) and the medication becomes more effective.

A clinical assessment at five to seven days will offer indications of the effect of a given daily dose. However, if a dose is clearly inadequate and there is no toxicity, the prescriber may increase the dose by as much as doubling it every day until a maximum of 24-32 mg/day is achieved. This is to be done in collaboration with community pharmacy and the patient is to be informed about the risk of side effects, particularly sedation. Note 24mg is the highest dose approved by HC.

BCCSU (2023) offers the following recommendations for titration:

- Select starting dose and titrate by 2mg–4mg every one to three hours based on withdrawal symptoms.
- Day one is complete once withdrawal symptoms are adequately relieved.
    - The day one max dose is 16mg/4mg, but higher doses may be reasonable to address persisting withdrawal symptoms.
- Prescribe the total day one dose for day two. If needed, continue the same titration process and stop at a dose that adequately relieves withdrawal symptoms and cravings.
- Daily doses of up to 32mg/8mg bup/nlx may be reasonable and can be provided safely to address high opioid tolerance. Note 24mg is the highest dose approved by HC.

2. Home Start

Some patients prefer to experience moderate withdrawal in a home setting rather than in an unfamiliar health care setting. Clinical guidelines have traditionally recommended that the initial dose of bup/nlx be supervised to allow for monitoring and support for adverse effects. This may be the preferred option for patients who are new to this medication or who would benefit from a clinician's support. However, home initiation may be considered for a well-informed patient if it is their preference.

One practical advantage with a home initiation is greater flexibility around timing. With pharmacy or clinic-based initiation, a patient might not yet have had a sufficient period of abstinence to be in moderate withdrawal when they are in the clinic, which is necessary for a standard bup/nlx initiation.

Also, the dose titration often requires that the medication be taken several times over the course of the day, which may be more convenient for a patient to do at home than in the clinic. See **Appendix C** for sample Home Initiation Schedules.

Home start follows the same dosing schedule as pharmacy or clinic initiation (i.e., first dose 2–4mg followed by subsequent doses q1–4h), but the patient is given an outpatient prescription or supply of bup/nlx to start at home when they are in sufficient withdrawal.

Before taking first dose, client is to make sure they are in opioid withdrawal. Usually, it takes several hours (12 hours or longer) after last use of an opioid to go into withdrawal. This can take even longer if methadone was taken. Encourage client to wait to take first dose of bup/nlx until they are certain they are in opioid withdrawal. Withdrawal symptoms can be assessed using the SOWS (Self-assessment of Opioid Withdrawal Symptoms) - see **Appendix D**.

Patients who may be particularly good candidates for home initiation include those:

- Who have previously completed a successful observed initiation with bup/nlx.
- Who have previously demonstrated capacity to take medications as prescribed, including previous opioid agonist therapy (OAT) medications.
- Who can adequately understand the risks of sedation and precipitated withdrawal when initiating bup/nlx.
- With no regular or heavy use of alcohol, benzodiazepines, or other sedative medications (including over-the-counter medications).
- Who express willingness to come into the office or attend an emergency department if problems arise during the initiation process.
- With the ability to securely store medications.
- With stable and supportive friends or family (as defined by the patient) who may assist in supporting and monitoring the home initiation process.

3. Micro-dosing (Low-dose Initiation)

For many individuals, a significant barrier to starting on bup/nlx is the requirement they must be in moderate to severe withdrawal to begin taking standard doses. Micro-dosing has emerged as an alternative to traditional pharmacy initiation and involves starting bup/nlx without the withdrawal requirement. Although the research evidence is limited, clinical practice in many jurisdictions now includes micro-dosing to reduce the risk of precipitated withdrawal, which may increase the likelihood of patient satisfaction and retention in treatment.

Also known as The Bernese Method, or low-dose initiation, micro-dosing involves slowly up-titrating small doses of bup/nlx, with cessation of all other opioids once a therapeutic dose has been reached. The theoretical basis for this strategy is that repetitive administration of very small doses of bup/nlx, with sufficient dosing intervals and a slow increase in the dose, can allow buprenorphine to accumulate at the opioid receptors, gradually displacing the full agonist opioids from these receptors so that withdrawal symptoms are minimized or prevented. Patients are encouraged to stop full agonist opioids when the bup/nlx dose is between 4 and 12mg.

Micro-dosing allows for more customized dosing but requires more intensive engagement with the care provider for several days. Prescribers will use clinical judgment to determine whether all-observed dosing, one observed dose and one unobserved dose per day; or all unobserved doses for a number of days are most appropriate for a specific patient. See **Appendix E** for sample Micro-dosing Schedules.

Tip: Prescribing the micro-dosing initiation to be dispensed in blister packaging can help reduce patient confusion regarding doses.

Clinicians might consider co-prescribing a full agonist (e.g., SROM, methadone, or as needed, hydromorphone) during the micro-dosing initiation, if clinically indicated. Benefits of initiating a patient onto SROM before the initiation of bup/nlx include helping the patient to avoid illicit opioid use while titrating up the bup/nlx dose, reducing their risk of overdose, and it may increase retention in care. When co-prescribing a full agonist, providers are encouraged to consult experienced prescribers, e.g. Addiction Medicine Consult Service.

4. Macro-dosing (High-dose initiation)

At the time of this writing, macro-dosing is an evolving off-label practice. Though less common, NS Health recognizes macro-dosing as an option. This rapid initiation protocol may be indicated for patients who engage in high-risk use (e.g., those that inject opioids or use fentanyl and/or high doses of opioids). Indicators for this approach are patients who are in withdrawal from fentanyl use or clients who have experienced full naloxone reversal of an opioid overdose.

Emerging evidence suggests that a sufficiently high dose of bup/nlx may be able to push beyond precipitated withdrawal by rapidly occupying a sufficient proportion of opioid receptors and, in doing so, rapidly initiate patients to a therapeutic dose of bup/nlx. Within one to three hours, most patients are comfortable and feeling no withdrawal symptoms.

Although macro-dosing protocols were initially developed for settings in which some degree of monitoring is available, anecdotally, some providers are prescribing unobserved bup/nlx for macro-dosing initiations that are managed remotely. When deciding whether to use this approach, providers will consider:

- Their level of clinical experience with buprenorphine and macro-dosing,
- Their level of experience and comfort in assessing opioid tolerance, and
- The supports available, which includes the ability to connect with a patient by telephone for reassessment and the ability of the patient to seek emergency medical assistance if required.

The Addiction Medicine Consult Service (AMCS) is available Monday to Friday 8:30 a.m. to 4:30 p.m., offering rapid telephone advice to physicians, pharmacists and nurse practitioners.

1-855-970-0234

META:PHI resource for macro-dosing initiation protocols can be found in **Appendix F**.

5. Rotating Methadone to Buprenorphine-Naloxone

Some patients who show a successful and sustained response to methadone may wish to transition to bup/nlx. This is an option for patients who:

- Request more treatment flexibility with dispensing.
- Prefer to transition to long-acting injectable buprenorphine (LAIB).
- Are experiencing side-effects or drug-interactions on methadone.
- Wish to stop OAT but have difficulty tapering off methadone and might better tolerate a taper from bup/nlx.
- Prolongation of the QTc interval is a concern.

The decision to transition to bup/nlx must be balanced with potential risks of destabilization, which may increase when transitioning from higher methadone doses.

Options to mitigate risk include slowly reducing methadone before making the transition, micro-dosing bup/nlx (**see Appendix G**) or switching to slow-release oral morphine (SROM) for five days after stopping methadone and before initiating bup/nlx.

ONGOING BUPRENORPHINE-NALOXONE TREATMENT

Frequency of scheduled appointments is a team decision, individualized for each client depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. It is important to strike a balance between monitoring and supporting the patient and to structure ongoing care in a way that is not overly intrusive, so that OAT remains acceptable to the patient.

Follow up visits may decrease with increasing clinical stability. Use clinical judgment to maintain an optimal individualized daily dose.

- Health Canada (HC) has approved a maximum dose of 24mg and recognizes that higher doses (up to 32mg) may be necessary for some patients.

- If exceeding 24 mg, inform the patient this is a departure from approved doses and there is limited evidence of a benefit with doses higher than 24 mg (and possibly an increased risk of adverse events).

As with any chronic condition, individuals with opioid use disorder are to receive comprehensive and continuing care. This includes ongoing review and assessment of the following:

- Adequacy of dosage.

- Any emerging side effects and drug-drug interactions.

- Physical and mental health.

- Need for, and access to, harm reduction services and supports.

- Psychosocial wellbeing and need for related supports including housing, relationships, finances, and connection to cultural services and supports.

Ongoing periodic prescriber appointments can be used for building therapeutic relationships, providing education about harm reduction and safe injection practices, offering supports and referrals to appropriate services, and promoting health and healthy behaviours.

Missed Doses

A. For missed doses with no return to full opioid agonist use:

- ≤ 5 days: resume previous dose.

- ≥ 6 days: adjust the dose based on the total daily dose and number of missed doses; for example:

TABLE 3

Missed Doses of Buprenorphine/Naloxone		
Missed Days	**Dose**	**Suggested Adjustment**
≥ 6 days	2 mg/0.5 mg–4 mg/1 mg	No change
≥ 6 days	6 mg/1.5 mg–8 mg/2 mg	Restart at 4 mg/1 mg
6-7 days	> 8 mg/2 mg	Restart at 8 mg/2 mg
≥ 7 days	> 8 mg/2 mg	Restart at 4 mg/1 mg

- If patient is on alternate-day doses, suspend bup/nlx until the patient can be reassessed. Then return the patient to a daily dose schedule, possibly at a lowered dose, to re-stabilize them before resuming an alternate-day schedule.

B. For missed doses due to return to full agonist opioid use:

- Prescribing is paused with destabilization, and low-barrier access should be offered to restart therapy when desired by the patient.

- Schedule a new initiation date and proceed as described in the Initiating OAT with bup/nlx section above.

C. For missed doses of LAIB:

- **Up to two weeks delay** in monthly injection (i.e., up to 42 days after last dose): Occasional delays of up to two weeks are not expected to significantly impact treatment effect. If a patient misses a monthly injection, they are to receive their next dose as soon as possible, and monthly injections should be resumed thereafter.

- **More than two weeks delay** in monthly injection (i.e., >42 days after last dose): Re-initiation is warranted. Patient is to be restarted on sublingual bup/nlx followed by a rapid transition to LAIB (see general initiation and dosing information above).

DISPENSING FREQUENCY

All patients are eligible for weekly dispensing of bup/nlx once started on treatment, unless the clinical care team has determined that it is unsafe to do so (e.g., unable to safely store medication, co-occurring sedative or alcohol use disorder compromising patient's safety). There should be documented clinical rationale if witnessed ingestion of bup/nlx is required.

Patients can progress from weekly to every other week dispensing after completing two months of random urine drug screens (one random per month) with no non-prescribed substance use.

Patients on bup/nlx who travel for employment, education or recreational purposes will be assessed on a case-by-case basis to determine dispensing quantity above this amount. Use clinical judgement when determining dispensing frequency for this purpose.

All patients with bup/nlx doses dispensed are required to sign an *OAT Dispensing Frequency Agreement* (see Appendix I) outlining patient's rights and responsibilities. Clinical team will review expectations and rights and responsibilities of patients to ensure patient can safely store medication.

Consider longer-interval dispensing frequency when the patient:

- Most importantly, has the **ability to safely store bup/nlx** in compliance packaging provided by pharmacy, and/or a lockbox (especially in household with children). A lockbox is not required for bup/nlx. Compliance packaging is considered best practice.
- Is not currently serving an intermittent sentence with corrections (i.e., weekends).
- Has no documented incidents of over sedation, intoxication, hospitalization or concerns of alcohol or benzodiazepine use compromising patient safety.
- Has reasonable and consistent access to a means of communication with the treatment team.

Consider shorter interval dispensing frequency when you estimate the benefits are exceeded by the risk of:

- Toxicity from dosing errors,
- Harm to others in the patient's environment from access to the patient's OAT,
- Therapy becoming ineffective due to medication non-adherence, and/or
- Victimization of the patient by others in their environment.

These risk estimations should consider the possibility of:

- substance interactions (prescribed; non-prescribed; over the counter; illicit; licit, including alcohol).
- un/intentional diversion and possible exposure to susceptible individuals.
- precarious social situations.

Note: The Nova Scotia College of Pharmacists (NSCP) Standards of Practice indicate that bup/nlx self-administration must be observed by a pharmacy team member unless otherwise noted on the prescription. If the patient is to remain under observation until the medication has dissolved (witnessed dispensing), this also must be indicated on the prescription.

Missed Prescription Pick-up

If patient misses more than one pick-up day in a period of two months, consider a team discussion to consider whether a different interval in dispensing frequency would benefit the patient.

URINE DRUG SCREENING (UDS)

Urine drug screening (UDS) is an important part of providing care to individuals with substance use disorders, from confirming baseline substance use to evaluating treatment outcomes. However, many individuals have had negative experiences with UDS. When UDS procedures are perceived as punitive, it can impact whether an individual will continue to access care.

Urine drug screens (UDS) are one tool that can be used to monitor and assess adherence to treatment, validate self-reported use of opioids or other substances, detect use of other substances that may increase risk for overdose (e.g., benzodiazepines), and evaluate treatment response and outcomes. However, as the extent of their utility and effectiveness is unclear, UDS results alone are insufficient to diagnose OUD. Screening tests are immunoassay (point-of-care, or in the lab) and are subject to false positives and negatives. Confirmatory tests are usually liquid chromatography/ tandem mass spectrometry or GC/MS (gold standard).

Through clinical judgement, other ways to assess and determine OUD include but are not limited to:

- Assessment of client presentation. Do they appear sedated? Have they missed appointments? Has their level of engagement changed?
- Signs of recent injection marks.
- Seeking collateral indications from family members, primary care provider, community pharmacy staff, etc.

The application of UDS is to be discussed with the patient and be based on the principles of improved patient care and outcomes. The frequency of testing will be determined by therapeutic need, understanding that more frequent UDS has not been shown to decrease substance use; however, a general principle of ‘more frequent testing at the beginning of treatment’ may be followed. Although urine samples will be supervised in clinical ORP settings, witnessed UDS may contribute to stigma, be experienced as a privacy violation, and should be avoided.

UDS are to be used for specific purposes, such as to:

- Confirm unregulated opioid use during baseline assessment.
- Support decision-making regarding dispensing frequency.
- Confirm that the medication is being taken.
- Screen for ongoing non-prescribed or unregulated opioid use, which may indicate the patient is undertreated or needs additional support.
- Detect the presence of other substances, including substances the patient may be unaware they have ingested.
- Evaluate treatment response and outcome.

When unexpected urine drug test results occur, and/or when a client disputes the results of UDS, further exploration with the team to review the overall clinical picture is to take place. Before changing the treatment plan, it is critical to discuss the unexpected results with the lab, the care team, and the patient. This reflection on safety may lead to an increased level of monitoring, and/or more frequent appointments for the next while. It is also recommended to repeat the point-of-care-test immediately (using a test from a different box).

TABLE 4

Treatment Stage	UDS Schedule for Patients Prescribed Bup/Nlx
Initial UDS	Not required to diagnose OUD but helps to confirm opioid use. Discussion of results can be useful to build rapport with patient and help reduce risk to the client, especially given the increased risk during the first couple of weeks of initiating OAT.
Initiation / Stabilization	Suggest **weekly** UDS for at least the first month, at the discretion of provider and for purposes of monitoring.
Ongoing	Frequency of scheduled appointments is a team decision, individualized for each client depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. It is recommended that UDS be completed at time of scheduled appointments as a tool for open communication. If client is unable to provide a sample, they should still be seen for their appointment. In addition, it is also recommended to request four (4) random UDS per year. If requesting more frequent random UDS, this should be clinically indicated and documented.
Dispensed Medication	Patients can progress from weekly (standard for bup/nlx) to every other week dispensing after completing two months of random urine drug screens (one random UDS per month) with no non-prescribed substance use.

SAFETY

Lock boxes are recommended (though not required) for the safe storage of bup/nlx doses to prevent children and others from ingesting fatal doses. The ceiling effect of bup/nlx for respiratory depression only applies to adults and therefore children are at higher risk if ingesting bup/nlx.

Patients are required to present compliance packaging quarterly, or less frequently at the discretion of the provider, to the ORP clinic for random pill counts at time of urine drug screen (UDS). See below for further guidance around UDS.

If there are safety concerns regarding sedation, diversion or safe storage, the care team has the flexibility to reduce the amount of medication dispensed at a time, and/or implement more frequent random UDS and pill counts to ensure safety guidelines are met.

Missed Random Pill Counts

If a patient does not attend their random pill count within the designated 48 hours, they will be asked to return for a clinic appointment and team discussion. Do not assume that all doses were diverted or that the individual has destabilized.

The team will decide collectively on how to proceed allowing flexibility to tailor the client's care based on the circumstance. Potential next steps could include:

- Clarifying random pill count expectations and responsibilities.
- Collecting a collateral history from family or community pharmacy.
- Increase pill count monitoring to monthly.
- Shorten length of time between clinic appointments.
- Increase frequency of UDS.
- If there is evidence of diversion, return to a shorter dispensing interval with reassessment of dose.

Lost or Stolen Doses

If patient reports lost or stolen doses:

- All lost/stolen doses will be replaced with witnessed dosing at community pharmacy.
- Switch from 6-day dispensing to twice per week dispensing for a period of 4 weeks. If there are no signs of instability or missed doses demonstrated during the 4 weeks, patient will return to 6-day dispensing.

Repeated incidents of lost or stolen doses will result in a team discussion and possible return to ongoing witnessed dosing at the community pharmacy.

TAPERS

OAT is an open-ended treatment. However, if a patient wishes to discontinue medication following a sustained period of stability on OAT (12 months or more preferred), a slow taper will be offered. Prescribing will only be stopped abruptly in cases of acute overdose, allergic reaction or clear diversion of a medication. If a patient has been taking their prescribed medication, abrupt termination will lead to opioid withdrawal.

Following OAT termination, subacute withdrawal symptoms can persist for months; however, most patients relapse to other opioid use or resume OAT before withdrawal becomes unmanageable.

Consider the following:

- Individuals who discontinue OAT are at increased risk of return to unregulated opioid use and related harms including drug toxicity death. Clinicians will discuss these risks with patients and advise ongoing engagement in treatment.

- Patients who expressly wish to discontinue treatment will be advised to consider a gradual taper that extends for as long as possible.

- Longer bup/nlx tapers (28 - 56 days) have been associated with improved outcomes at completion (abstinence from non-medical opioid use, retention in treatment) compared to shorter bup/nlx tapers (7 - 28 days).

- Evidence suggests that a longer time in treatment prior to initiating the taper (>52 weeks vs. <12 weeks) shows higher rates of successful taper and lower risk of subsequent opioid overdose.

- An opioid agonist taper involving bup/nlx appears to reduce the severity of withdrawal symptoms, and most patients still relapse to opioid use if a strategy involving only withdrawal management is employed.

Buprenorphine may offer some advantages over methadone when used during a taper, specifically offering faster symptom relief. There does not appear to be a significant difference in terms of withdrawal symptom severity, withdrawal treatment completion, or average treatment duration for individuals managed with bup/nlx compared to methadone.

- With methadone, the onset of acute withdrawal is usually over a period of 24 to 72 hours and peaks three to four days after the last dose. It can last for 15 to 20 days.

- With bup/nlx, the onset of acute withdrawal is typically closer to 48 hours, with a peak at three days and a duration of 10 days.

Compared to alpha2-adrenergic agonists, bup/nlx appears to offer more effective relief of withdrawal symptoms, as indicated by the lower overall withdrawal score, longer retention in treatment, and greater likelihood of completing treatment. There does not appear to be a significant difference between bup/nlx and alpha2-adrenergic agonists in adverse effects except in comparison with clonidine, which is associated with higher rates of drop-out due to side effects.

Slow-Release Oral Morphine (SROM)

Coming Soon

Methadone

Coming Soon

OAT Treatment Completion

Coming Soon

Indications that Patient is (or not) Benefitting from OAT

Indications the Patient is Benefitting from OAT

Clinical Benefits

- Reduced (or cessation of) illicit substance use.
- Reduced risk and incidence of overdose due to reduction or cessation of illicit opioid use.
- Reduced cravings.
- Reduced potential communicable disease exposure and infection.
- Reduced emergency department or acute care usage.
- Increased engagement in primary care and other health services.
- Management of withdrawal symptoms.
- Patient report of improved overall wellbeing.
- Urine drug screens consistently positive for prescribed medications.

Psychosocial Benefits

- Reduced need to engage in high-risk and criminalized activities (e.g., sex work) to support substance use.
- Maintaining, seeking, or gaining employment or volunteer activities.
- Improved attitude toward self.
- Ability to set and meet goals in major areas (e.g., personal health, career).
- Enrolled in education or training programs.
- Integrating new activities.
- Reconnecting with family and friends (e.g., improved social functioning)
- Attaining safe housing and accessing other social services.

Indications the Patient is Not Benefitting from OAT

- No change or increased intensity of illicit substance use.
- No change or increased overdose risk.
- Ongoing cravings and withdrawal symptoms.
- Urine drug tests consistently negative for prescribed substance.
- No change in wellbeing or social functioning.
- Consistently missed doses.
- Development or worsening of mental or physical health conditions associated with prescribed medications.

SPECIAL CONSIDERATIONS

Some individuals and communities may have unique health needs or circumstances due to biological, societal, or resource-related factors. A brief overview of additional considerations are offered below.

1.Concurrent Mental Health Disorders

All patients who present with opioid use disorder will be screened for:

- Concurrent mental health disorders (e.g., anxiety, depression, posttraumatic stress disorder [PTSD], personality disorders)
- Suicidal ideation
- Trauma and abuse (past or current)

Those who screen positive are to be offered a referral to counselling services and receive evidence-based treatment for all conditions, if they express interest.

Assess patients periodically for alcohol, nicotine and other substance use, and offer appropriate psychoeducation and treatment. **Using cannabis, stimulants or other addictive substances is not a reason to suspend OAT.**

To support effective integrated care for individuals with concurrent substance use and mental health disorders, best practice is to use an integrated and collaborative care model wherein the level of care is dependent on the severity of each disorder.

Other recommendations include:

- **Mitigate the risk of drug toxicity death** - while concurrent treatment is recommended, stabilization on OUD treatment - including initiation of OAT - may be initially prioritized for patients with severe OUD in cases where simultaneous initiation of treatments is not feasible.
- **Be knowledgeable about local mental health and addiction resources**, including wait lists, costs and practitioner expertise and approach in order to provide informed referrals that reflect patient needs and preferences. If they do not respond to primary care–led treatment, or if they require specialized care, refer them to a mental health professional, and reassess periodically during OUD treatment.
- **Avoid co-prescribing benzodiazepines (BZRAs)** to patients on OAT due to increased risk of respiratory depression, daytime hypersomnolence, cognitive disturbance and overdose death. If clinical assessment, preferably by an addiction psychiatrist, suggests that a trial of BZRAs may be warranted, be aware of the interaction between the BZRA and OAT, adjust the dose and timing accordingly, and consider reduction in dispensing frequency to match OAT dispensing interval.

- **Evaluate the indication for OAT patients who are already on long-term BZRAs.** The decision to continue prescribing or to de-prescribe the BZRA needs to be made with attention to other confounding diagnoses, including sedative use disorder and PTSD.

- **Attempt to decrease the BZRA dose or taper the patient off** the medication, particularly if they:
  - Have respiratory disease or sleep-disordered breathing,
  - Show signs of misuse,
  - Are older adults, **or**
  - Are on:
    - multiple daily doses.
    - a high OAT dose,
    - other medications or substances with sedating properties.

- **Collaborate with pharmacists** to prevent, monitor and manage drug interactions between OAT and other prescription or non-prescription medications a patient may be taking. Methadone interactions require particular attention.

2. Managing Acute/Chronic Pain

Acute Pain

Adequate pain management is vitally important to successful inpatient care. Given the lack of evidence supporting improved outcomes with the discontinuation of bup/nlx in the context of acute pain, and the high mortality risk associated with untreated opioid use disorder, bup/nlx should not be routinely discontinued in the context of acute pain or surgery. The main recommendation is to continue buprenorphine treatment in the perioperative period.

Available evidence and guidance indicate that patients' OAT dose should be continued and may be increased, split, or increased and split to treat pain. The baseline OAT dose will not address acute pain. When opioids would normally be indicated for the treatment of an acute medical condition, opioids should still be given to a person actively receiving opioid agonist therapy and may need a higher dose because of the development of tolerance. Non-opioid adjuncts (e.g., clonidine, ibuprofen, acetaminophen) may be considered for pain control.

Chronic Pain

Although OAT may help with chronic pain management for some individuals, patients presenting with chronic pain should have access to additional services for pain management. In situations where more than one opioid is prescribed, the duration of opioid co-prescribing should be pre-determined when possible, and the patient should be informed of the timeline at the outset. Encourage patients to attend a primary care provider or team for ongoing preventative care and chronic disease management. Communicate openly and regularly with the patient's care providers.

The Addiction Medicine Consult Service (AMCS) is available Monday to Friday 8:30 a.m. to 4:30 p.m., offering rapid telephone advice to physicians, pharmacists and nurse practitioners.

1-855-970-0234

3. Polysubstance Use

Ongoing substance use while on OAT may be an indication to modify treatment accordingly. Possible treatment modifications may include dose increases, transitioning to another OAT medication, or increasing psychosocial and other supports. In cases where treatment modification is indicated, clinical judgment should be used in determining what specific types of adjustment are appropriate. In such cases, harm reduction and overdose prevention measures are to be discussed and reinforced.

Patients will be advised of the risk of overdose due to contamination of the unregulated drug supply with fentanyl and other highly potent synthetic opioids (including non-opioid substances such as benzodiazepines, stimulants, and xylazine) and receive education on harm reduction strategies and, where possible, access to a variety of harm reduction resources, including:

- Take-home naloxone.
- Drug checking services.
- Observed consumption services.
- Test strips for fentanyl and benzodiazepines.
- The Toxic Drug and Health Alerts text messaging system.
- If using alone:
  - Overdose prevention apps, such as the Lifeguard app, if using alone
  - National Overdose Response Service (NORS): 1-888-688-NORS (6677) call or text.

Drug-checking and fentanyl test strips are not well validated and are not available everywhere.

If a patient is continuing to use unregulated opioids at the same intensity despite intensification of treatment, their reasons for continued reliance on the unregulated drug supply should be explored collaboratively, and clinical judgment should be used to determine appropriate follow up. Prescribed safer supply may be an appropriate harm reduction option to consider at this point.

Stimulants

If patients are using stimulants (e.g., cocaine or methamphetamine) while receiving OAT, consider increasing psychosocial interventions and supports, such as implementing contingency management. In some cases, it may be beneficial to consider combining OAT with inpatient treatment, which will facilitate the close monitoring and the incorporation of psychosocial strategies to reduce stimulant use (e.g., counselling, contingency management). For more information on treatment options for stimulant use disorder, please see the **BCCSU's Stimulant Use Disorder Practice Update**.

Sedatives
Ongoing sedative use may indicate a need to modify treatment. Clinical judgment should be used to determine which interventions are appropriate for each patient.

Alcohol

- For individuals on OAT who meet criteria for high-risk drinking but do not have an Alcohol Use Disorder (AUD), brief intervention has been found to reduce alcohol consumption. Motivational interviewing may also be effective for reducing high-risk drinking in patients prescribed OAT.

- For patients diagnosed with co-occurring AUD and OUD, AUD pharmacotherapy should be offered with consideration of drug-drug interactions with OAT, as applicable.

    - Bup/nlx may be a preferred OAT medication however, patient preference and individual circumstances are key considerations. Continued unregulated opioid use poses a higher risk of harm than any OAT medication.

    - For more information on treating individuals with co-occurring AUD and OUD, please see the BCCSU's **Managing Co-occurring Opioid Use and Alcohol Use Disorders** bulletin.

    Co-prescribing:

    - **Acamprosate** can be considered along with evidence-based psychosocial treatment interventions and supports for treating concurrent AUD. Acamprosate has an established evidence base for safety and efficacy for the treatment of AUD and does not pose significant safety risks when used concurrently with CNS depressants.

    - **Topiramate** may be considered for the treatment of AUD in patients who are also on OAT in cases where acamprosate is not appropriate. Topiramate has not been well studied for the treatment of AUD in patients with concurrent OUD; however, the efficacy of this medication for the management of AUD is supported by an established body of evidence, and it is not contraindicated for patients who use CNS depressants concurrently.

    - Use caution when considering **gabapentin** for AUD treatment for a patient on OAT. Although gabapentin has a growing evidence base supporting its use for withdrawal management and preliminary evidence supporting its use in relapse prevention for AUD, this medication may heighten the euphoric effects of opioids and increase the risk of respiratory depression and overdose if used at moderate-to-high doses concurrently with opioids. If these medications are co-prescribed, clinicians should be aware of these risks and monitor patients appropriately.

Benzodiazepines

- Co-occurring use of benzodiazepine receptor agonists (BZRAs; benzodiazepines and z-drugs) and opioids significantly increases the risk of respiratory depression, overdose, and death. When prescribing OAT, all patients are to receive education on the risks of combining opioids and BZRAs, even if medications are taken as prescribed.

- Benzodiazepines are to be included in urine drug screens for individuals who use unregulated opioids and/or those who are on OAT. However, clinicians and patients are to be aware that some benzodiazepines and benzodiazepine analogues (e.g., alprazolam, clonazepam, etizolam, temazepam, triazolam) may not be detected in standard urine drug screens despite the patient having been exposed.

- Traditionally, prescribing OAT to patients also taking benzodiazepines has been contraindicated. However, due to the high risk of overdose death associated with unregulated opioid use, it is not advised to delay or withhold OAT for patients who use benzodiazepines or if benzodiazepine exposure through the unregulated drug supply is suspected. However, **patients are not be started on OAT while sedated.**

- As soon as a patient is stabilized on OAT, the prescribing clinician will review the indication for BZRA use and diagnose any underlying sedative use disorder. The clinician will inform the patient of the risks of concurrent opioid and BZRA use and offer to initiate a BZRA taper. During a BZRA taper, consider dispensing BZRAs at the same frequency as OAT medications; monitor patients closely for symptoms of opioid withdrawal, as breakthrough symptoms can emerge when BZRA dose is reduced; and advise patients that any take-home OAT and BZRA doses must be safely stored (e.g., in a locked box).

Cannabis

Patients who are using cannabis recreationally may benefit from a discussion of the recommendations made in the **Lower-Risk Cannabis Use Guidelines**. Patients who are using medicinal cannabis will be monitored by their OAT prescriber to ensure the benefits they receive outweigh the potential harms.

Psychedelics

Some individuals try to self-treat their opioid use disorder with psychedelics. Patients reporting psychedelic use are to receive education on harm reduction and be advised there is no evidence to date that psychedelics can be used to treat opioid use disorders.

4. Correctional Health Services

Health care providers must be aware of the importance of maintaining OAT care for patients who transition in and out of correctional settings. Specific guidance for the treatment of OUD in correctional settings is beyond the scope of this guideline.

When requested by the correctional facility, the patient's regular OAT prescriber should:

- Provide all information necessary for safe and effective OAT.
- Collaborate with the prescriber working in the correctional facility and with the community pharmacist, if applicable, to ensure continuity of care before (and at the time of) release.

5. Individuals Experiencing Insecure Housing

Individuals experiencing homelessness, or insecure or insufficient housing, face significant barriers accessing and being retained in OUD care. Challenges include:

- Accessing health care services in general.
- Lack of knowledge regarding care options.
- Lack of ID or health card.
- Lack of transportation.
- Lack of childcare.
- Lack of conditions to safely store OAT medications.
- Previous and anticipated experiences of discrimination in health care settings.

Specific aspects of OUD care (e.g., frequent appointments with clinicians, daily visits to a pharmacy to pick up OAT medication) present further barriers to treatment access for individuals who experience insecure housing.

Clinicians can better support individuals who are insecurely housed by:

- Working collaboratively with patients to determine a treatment plan.
- Providing flexible appointments.
- Dispensing frequency as appropriate. Unwitnessed dosing can be considered for patients starting on bup/nlx that demonstrate clinical and psychosocial stability and are able to safely store the medications.
- Connecting patients with resources to meet their other health, social, and survival needs (e.g., specialist care, housing, food/nutrition, financial assistance, employment, outreach services) as requested or appropriate.

People who experience homelessness who present in emergency departments may be candidates for an emergency department bup/nlx initiation.

6. Indigenous Peoples

Recent evidence emphasizes the importance of culturally safe and informed approaches to reduce disparities in substance use care for Indigenous populations. This guideline strongly recommends that all health care providers and staff participate in Indigenous cultural safety and cultural humility training to improve their ability to establish safe, positive partnerships with Indigenous patients, families, and communities.

Indigenous approaches to health are holistic, relational, and seek to balance physical, spiritual, mental, and emotional wellness. However, many clinicians who provide substance use care subscribe to a biomedical approach that is disease - and individual-focused - an approach that has been acknowledged as largely incongruent with Indigenous worldviews.

Conventional substance use care has been shown to be less effective for, and potentially harmful to, Indigenous people. Some suggest this may be due, in part, to the lack of cultural practices incorporated into treatment interventions and a delivery of care model that does not honour Indigenous values and worldviews. Mi'kmaq Elder, **Albert Marshall's, "Two-Eyed Seeing"** approach has been widely valued and recognized in holistic wellness and substance use care for Indigenous peoples, as it respects and integrates the strengths of both Indigenous knowledge and Western medicine.

Click this link for more information about **supporting OUD and OAT in First Nations Communities**.

7. Cultural Safety and Competency

Cultural safety refers to the process of making spaces, services, and organizations safer and more equitable for people who are marginalized, oppressed, and/or underserved because of their identities. Being culturally competent is critical to offering safe and inclusive health care. It is essential that health providers consider their own inherent biases and worldviews and reflect upon how these may impact the way they perceive and interact with others. OAT providers and ORP team members are encouraged to participate in education and training that enhances their perspective on cultural humility.

8.Older Adults

While this guideline is intended to be applicable to adults aged 19+, there are unique considerations for older adults (age 65 and above). For specific guidance on prevention, screening, assessment, and treatment of OUD in older adults, as well as an overview of the issues unique to this population, please refer to the **Canadian Guidelines on Opioid Use Disorder Among Older Adults**

Some recommendations include:

- Offer medications for OUD in the context of connection to long-term addiction, mental health, and primary care treatment, where careful monitoring and dose titration can occur.

- Ensure patients understand the use of alcohol, benzodiazepines, and other sedative-hypnotics is hazardous when combined with OAT.

    - If the older adult is living in the community and is already physiologically dependent on one of these substances, then slow tapering of the substance(s) (to elimination if possible) rather than abrupt cessation is recommended.

    - If the patient is in hospital, inpatient treatment, or a long-term care setting and medically managed by an experienced provider, detoxification can progress more rapidly, concurrent with the initiation or stabilization on medications for OUD.

9. Individuals Living or Working in Rural/Remote Areas

Several strategies have been identified for providing effective OUD care to individuals in rural and remote settings, including those who work remotely for long periods of time. Lack of psychosocial services is not a barrier to initiating and continuing OAT. Higher retention rates on OAT are attributable to increased acceptability and convenience when patients can remain in their communities to initiate and be maintained on OAT.

Health care providers can determine how to adapt the recommendations in this guideline to reduce barriers for patients. For example, flexible dispensing frequency can be considered in situations where daily visits to pharmacy are not feasible due to distance or other limitations. All adaptations to the recommendations should have a clear rationale, take patient and community safety into consideration, and be documented.

Nurses can play a key role in increasing access to and retention in OUD care in rural and remote settings, as they are often the primary care providers in these communities.

Another strategy is the wider adoption of virtual care (often called telehealth) in delivering OUD care (see section on Virtual Care for more details). Virtual care enables providers to consult with patients from a distance, eliminating the need for and additional costs of patient travel to other communities. While telehealth has demonstrated effectiveness in rural populations, few studies have been conducted examining OUD care specifically.

Recommendations include:

- Collaborate with available services to prescribe OAT in a safe and accessible way for the patient, regardless of geographical location.

- Be prepared to initiate OAT using approaches such as virtual care in partnership with local resources (e.g., Nurse Practitioners).

- Recognize bup/nlx as the best option for improving treatment retention and outcomes in areas where access to care is limited and daily witnessed ingestion of methadone at a pharmacy is not practical.

- Consider LAIB to reduce barriers to care and increase retention in treatment.

10. Pregnancy

OAT has long been the standard treatment for OUD in individuals who are pregnant as it has been shown to eliminate or substantially reduce illicit opioid use with minimal adverse effects on the fetus in comparison to rapid withdrawal management and untreated OUD. Pregnancy is associated with increased access to healthcare services and motivation for recovery, presenting an important opportunity to engage patients in treatment for substance use. Untreated OUD during pregnancy is associated with numerous adverse outcomes, including fetal growth restriction, fetal demise, and neonatal abstinence syndrome (NAS).

Based on current evidence, health care providers can safely recommend buprenorphine/naloxone in pregnancy based on current data. Consequently, switching patients to a buprenorphine-only product is not necessary. Pregnancy was removed as a contraindication in the Health Canada-approved bup/nlx product monograph. Due to its superior safety profile, bup/nlx may be especially advantageous compared to methadone in locations where access to specialized care, including daily dispensing requirements for methadone, is limited. **LAIB, however, is contraindicated for individuals who are pregnant.** If patient conceives while on LAIB, consider switching to bup/nlx and counsel around potential risks.

In cases where patients have achieved clinical stability on bup/nlx prior to pregnancy, continuation of this treatment is recommended. Transition to buprenorphine monotherapy during pregnancy is not necessary but may be offered to a patient who is fully informed of treatment options and wishes to proceed with buprenorphine. The risks and benefits of transitioning from bup/nlx to another OAT agent should be carefully considered under the guidance of a specialist and discussed with the patient and their family (if appropriate).

Bup/nlx dosing principles for pregnant individuals do not differ from the general adult patient population (i.e., individually titrated doses that eliminate or sufficiently reduce withdrawal symptoms). Manage opioid withdrawal symptoms by increasing the dose of bup/nlx and/or administering in divided doses until the postpartum period. Pregnant individuals who seek treatment are often prescribed pharmacological interventions that are insufficient in dose and/or duration. **Health care providers who are not experienced in treating OUD during pregnancy should consult an addiction medicine specialist.**

The Addiction Medicine Consult Service (AMCS) is available Monday to Friday 8:30 a.m. to 4:30 p.m., offering rapid telephone advice to physicians, pharmacists and nurse practitioners.

1-855-970-0234

Further recommendations include:

- Consider split doses of methadone and buprenorphine, especially in later pregnancy, due to enzyme induction, reduced elimination half-life and increased volume of distribution. Dose increases may be avoided by dividing doses (i.e., two, three or four times daily).

- Consider take-home doses of methadone for split dosing even in pregnant patients who may not otherwise be offered them if improved neonatal outcomes and reduced illicit substance during pregnancy justify the potential risks of take-home dosing.

- Ensure adequate analgesia (opioid and maximized non-opioid pharmacotherapies) during delivery, in addition to any OAT prescribed for baseline needs.

- Monitor patients closely postpartum for the need to adjust the OAT dose.

11. Sex /Gender /Sexuality

Sex and gender are important determinants of health that can influence the physiological and psychosocial aspects of many health conditions, including substance use disorders. Several clear trends regarding gender and opioid use have been identified, related to harms from opioid use, risk factors, and access to service:

- Opioid poisonings, both fatal and non-fatal, tend to be higher among men than women.

- Men are more likely to have been arrested or be under legal supervision, which can lead to loss of tolerance and disruption of income, in turn resulting in greater harm when opioid use is resumed.

- Women face their own set of risks and gender-specific factors related to opioid use, including significant psychiatric, economic, and infectious disease vulnerabilities compared to men.

- Despite intention for [many opioid recovery programs] to be gender-neutral, women may face additional barriers to accessing OAT, which may be alleviated by offering women-only service or hours.

- Two-spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, asexual and other gender and sexually diverse people (2S/LGBTQQIA+) face unique challenges as a result of social prejudice and discrimination, internalized stigma, and lack of health care provider competencies specific to these groups.

Data on OUD specifically in 2S/LGBTQQIA+ individuals is limited; however, given the high rates of substance use in some 2S/LGBTQQIA+ communities, OUD treatment should be culturally sensitive and include an awareness of the issues that 2S/LGBTQQIA+ individuals are likely to face. Strategies for working with 2S/LGBTQQIA+ individuals include:

- Actively communicating that services are available for 2S/LGBTQQIA+ patients.
- Building relationships with organizations serving diverse marginalized communities.
- Using inclusive language in forms and clinical materials and during appointments.

12. Youth

While this guideline is intended to be applicable to all adults aged 19+, there are unique considerations for adolescents (age 12-17) and young adults (18-25), collectively referred to as "youth" in this document.

Some practitioners may be hesitant to prescribe OAT to youth, due to reluctance to start them on what is frequently considered a long-term treatment, as well as concern over bringing youth into daily contact with adult patients (if youth-specific OAT services are not available). These concerns are to be carefully weighed against the risks of discontinuing or not starting pharmacotherapy and continued drug use including overdose, HIV, viral hepatitis, and other morbidity and mortality factors.

Whenever possible, prescribers should have experience working with this population and should collaborate with youth counsellors. Consult an experienced colleague to assist with assessing the role of OAT if you do not have the knowledge, skills or resources to treat adolescents with OUD.

While evidence is limited related to bup/nlx treatment in youth:

- Buprenorphine used as analgesia has been shown to be safe and effective in adolescents.
- An evaluation of adolescents aged 15-18 receiving bup/nlx for OUD found it to be well-tolerated by most.
- Bup/nlx is effective in reducing opioid use in young adults aged 18-25, although reported retention rates are notably lower than those observed in older adults.

The lack of customized, age-appropriate approaches to, and options for, substance use care are often cited as barriers to engaging and retaining youth in treatment. Some strategies that health care providers can use to improve youth retention and engagement in care include:

- Emphasize confidentiality within and across services.
- Include family members and other caregivers (e.g., trusted Elders, teachers, outreach workers, counsellors, as well as friends and romantic partners) in care when appropriate.
- Foster respect, trust, and the development of longitudinal therapeutic relationships.

- Offer the full scope of pharmacotherapy when indicated.
- Ensure youth have coverage to be able to afford the OAT (through Pharmacare or other means).
- Provide referrals to youth-oriented psychosocial treatment interventions and supports.
- Ensure timelines are adequately discussed with youth and that treatment is provided without a pre-determined end date.
- Inclusion of peer support staff or referrals to peer support services in the community may support a youth-centered approach to care.

Encourage and facilitate engagement in non-pharmacological treatment (e.g., recovery-oriented services) to complement OAT. You should be familiar with the programs to which you refer adolescents and feel comfortable that they offer evidence-based treatments that support patients on OAT.

Placeholder - Virtual Care

In development

Placeholder - Prescribing Other Medications

TBD

REFERENCES

BC Centre for Substance Use and Addictions. (2023). A Guideline for the Clinical Management of Opioid Use Disorder. https://www.bccsu.ca/wp-content/uploads/2023/12/BC-OUD-Treatment-Guideline_2023-Update.pdf

BC Centre for Substance Use and Addictions. (2022). Stimulant Use Disorder Practice Update. https://www.bccsu.ca/wp-content/uploads/2022/06/Stimulant-Use-Disorder-Practice-Update_June2022.pdf

BC Centre for Substance Use and Addictions. (2021). Managing Co-occurring Opioid Use and Alcohol Use Disorders. https://www.bccsu.ca/wp-content/uploads/2021/04/ATG-Managing-Co-occuring-Opioid-and-Alcohol-Use-Disorders.pdf

Canadian Coalition for Seniors Mental Health. (2019). Canadian Guidelines on Opioid Use Disorder Among Older Adults. https://ccsmh.ca/wp-content/uploads/2019/11/Canadian_Guidelines_Opioid_Use_Disorder_ENG.pdf

Canadian Research Initiative in Substance Misuse. (ND). Lower-Risk Cannabis Use Guidelines. lrcug_professional-pdf.pdf (camh.ca)

Canadian Society of Addiction Medicine. (2022). Choosing Wisely Canada: Addiction Medicine. https://choosingwiselycanada.org/recommendation/addiction-medicine/

Centre for Addictions and Mental Health. (2022). Opioid Agonist Therapy: A Prescriber's Guide to Treatment 3rd Ed. Toronto, Canada.

Centre for Addictions and Mental Health. (2021). Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. https://www.camh.ca/-/media/files/professionals/canadian-opioid-use-disorder-guideline2021-pdf.pdf

First Nations Health Authority. (2022). Supporting Opioid Use Disorder and Opioid Agonist Therapy in First Nations Communities. https://www.fnha.ca/Documents/FNHA-Supporting-Opioid-Use-Disorder-and-Opioid-Agonist-Therapy-in-First-Nations-Communities.pdf

Marshall, Albert. (28 September to 1 October 2017). Two-Eyed Seeing: Guiding Principle for Inter-cultural Collaboration. Pugwash, NS. [From Thinkers Lodge. Climate Change, Drawdown & the Human Prospect: A Retreat for Empowering our Climate Future for Rural Communities]. http://www.integrativescience.ca/uploads/files/Two-Eyed%20Seeing-AMarshall-Thinkers%20Lodge2017(1).pdf.

Mentorship, Education and Clinical Tools for Addiction: Partners in Health Integration. (ND). Buprenorphine Macrodosing Initiation. https://www.metaphi.ca/wp-content/uploads/MacrodosingOnePager.pdf

Mentorship, Education and Clinical Tools for Addiction: Partners in Health Integration. (ND). Buprenorphine/Naloxone (Suboxone®): Reference Guide for ED Providers. https://www.metaphi.ca/wp-content/uploads/ED_OUD_ReferenceGuide.pdf

Mentorship, Education and Clinical Tools for Addiction: Partners in Health Integration. (ND). Home Induction. [Pamphlet]. https://www.metaphi.ca/wp-content/uploads/Pamphlet_HomeInduction.pdf

Nova Scotia College of Pharmacists. (2023). Standards of Practice: Opioid Agonist Maintenance Treatment Services. (draft)

Nova Scotia College of Pharmacists. (2022). Standards of Practice: Opioid Agonist Maintenance Treatment Services. https://www.nspharmacists.ca/wp-content/uploads/2017/07/SOP_OpioidAgonistMaintenanceTreatmentServices.pdf

APPENDIX A - DECISION SUPPORT TOOL FOR SELECTING OAT

Adapted from BSSCU (2023)

	Buprenorphine-based formulas		Methadone	SROM
	Buprenorphine/ Naloxone	**Long-Acting Injectable Bup**		
Retention in treatment	May be slightly lower than methadone; retention improves at higher does (above 16mg).	Substantially higher than placebo.	Potentially slightly better treatement retention than buprenorphine/ naloxone.	Non-inferior to methadone.
Initiation				
Requires withdrawal prior to initiation	**Traditional initiation:** Yes. Requires moderate withdrawal prior to induction. **Low-dose initiation:** No. Does not require prior withdrawal, allowing for comfortable start.	No. Does not require a period of withdrawal, but requires prior stabilization on sublingual buprenorphine/ naloxone.	No. Does not require a period of withdrawal. May be easier to initiate.	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration.
Time to achieve therapeutic dose	**Traditional initiation:** **(**1-3 days) Shorter time to achieve therapeutic dose. **Low-dose initiation:** (5-10 days) Takes longer to reach therapeutic dose.	Two months on 300mg injections, followed by 100mg maintenance dose.	(May take weeks) Longer time to achieve therapeutic dose.	1-2 weeks
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on sublingual bup/nlx prior to initation	N/A	N/A

	Buprenorphine-based formulas		Methadone	SROM
	Buprenorphine/ naloxone	Long-Acting Injectable Bup		
Side Effects				
Side effects	Milder side effects profile	Medication adverse effects are similar to buprenorphine/ naloxone	More severe dose-dependent side effect profile (e.g. sedation, weight gain, erectile dysfunction, and cognitive blunting)	Comparable to methadone, though less well-described Possibly fewer subjective side effects
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants.	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants.	Higher. Particularly during treatment initiation.	Comparable safety profile to methadone, though less well-described.
Drug-drug interactions	Few	Few	Higher potential for adverse drug-drug interactions (e.g. antibiotics, antidepressants, antiretrovirals).	Fewer than methadone
Risk of precipitated withdrawal during initiation	Yes	No	No	No
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated

	Buprenorphine-based formulas		Methadone	SROM
	Buprenorphine/ naloxone	**Extended-release buprenorphine**		
Rotation				
Rotation	Easier to rotate from Buprenorphine/ naloxone to methadone or SROM.	Comparable to Buprenorphine/ naloxone	Risk of precipitated withdrawal when rotating buprenorphine/ naloxone. May be rotated directly to SROM.	Risk of precipitated withdrawal when rotating buprenorphine/ naloxone. May be rotated directly to methadone.
Tapering off				
Tapering	Milder withdrawal symptoms; easier to discontinue. May be a better option for individuals with lower-intensity physical opioid dependance.	Milder withdrawal symptoms. Buprenorphine concentrations are decreased slowly over time following the last injection and may take months for buprenorphine to leave the system completely.	More severe withdrawal symptoms.	Comparable to methadone.

	Buprenorphine-based formulas		Methadone	SROM
	Buprenorphine/ naloxone	**Extended-release buprenorphine**		
Dosing				
Dosing	Health Canada - approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some people. Alternate day dosing possible. May be suboptimal for some individuals with very high opioid tolerance.	First two month dose: Monthly dose of 300mg Maintenance dose: monthly dose of 100mg (though some patients may benefit from remaining at a 300mg maintenance dose).	TBD with NS Health *Methadone Guidelines* (coming soon)	TBD with NS Health *SROM Guidelines* (coming soon)
Dispensing Frequency	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased people autonomy and cost savings. Advantageous for rural and remote locations.	N/A	TBD with NS Health *Methadone Guidelines* (coming soon)	TBD with NS Health *SROM Guidelines* (coming soon)

APPENDIX B -
SAMPLE PRESCRIPTION SCRIPT

COMING SOON

APPENDIX C - SAMPLE HOME INITIATION SCHEDULES

Sample 1 of 2 - Direction 180

Day 1:
Client should stop taking all opioids 12 - 36 hours before taking first dose. Client should be feeling withdrawal symptoms.

Client takes 4 mg of bup/nlx under the tongue (tablet or film strip). (Half of an 8 mg tablet, or two 2 mg tablets, usually one film strip).

- If client feels fine after 1 hour, do not take any more medication today. Client records total for the day.
- If client continues to have withdrawal symptoms after 1 hour, client takes a second dose (4 mg).
- If client feels worse than when they started, they might have precipitated withdrawal. Advise them to talk with their provider about treatment options.

Wait 1-2 hours.

- If client feels fine, do not take any more medication today. Client to record total for the day.
- If client continues to have withdrawal symptoms, take a third dose (4 mg).

Wait 1-2 hours.

- If client feels fine, do not take any more medication today. Client to record total for the day.
- If client continues to have withdrawal symptoms take a fourth dose (4mg).

Day 2:
If client's Day 1 total was **4 mg**:

- If client feels fine, take 4 mg this morning.
- If client feels some withdrawal symptoms, start with 8 mg this morning.
- Later in the day, if client feels okay, do not take more. If client still feels withdrawal, they take another 4 mg dose.

If client's Day 1 total was **8 mg**:

- If client feels fine, take 8 mg this morning.
- If client feels some withdrawal symptoms, start with 12 mg this morning.
- Later in the day, if client feels okay, do not take more. If client still feels withdrawal, they take another 4 mg dose.

If client's Day 1 total was **12 mg**:

- If client feels fine, take 12 mg this morning. Client might want to split the dose into a morning dose (6 mg) and afternoon dose (6 mg).
- If client feels some withdrawal symptoms, start with 16 mg this morning.
- Later in the day, if client feels okay, do not take more. If client still feel withdrawal, they take another 4 mg dose.

Day 3:

- If client felt good at the end of Day 2, repeat the dose from Day 2. If the dose was more than 8 mg, client might want to split the dose into a morning dose (6 mg) and afternoon dose (6mg).
- If client felt too tired, groggy, or over-sedated on Day 2, take a lower dose on Day 3 (2-4 mg less).
- If client still felt some withdrawal at the end of Day 2, take the same total dose as taken on Day 2 plus another 4 mg dose.
- If withdrawal symptoms persist, take another 4mg dose.
- If symptoms persist, client to consider seeing their provider in the office.

**** Do not take more than 32 mg of bup/nlx in one day. * (Note: 24 mg is the highest dose approved by HC)***

Day 4 & beyond:

- Client to take the total dose used on Day 3.
- Client can take more or less medication, depending on how they feel overall, if they still have cravings, or if they are still using.

At this point, client should discuss any dose adjustments with their doctor. If client needs to increase their dose, they should not change it by more than 4 mg per day.

Sample 2 of 2 - Metaphi

Day 1:

- Client's first dose will be either 2mg (one tablet) or 4mg (two tablets).
- Client should start to feel better within an hour or two of first dose. If client feels well, don't take any more.
- If client still feels sick after two hours, take another 2mg (one tablet) or 4mg (two tablets).
- Client can take 2-4mg (one or two tablets) every two hours to a maximum of 16mg (eight tablets) on the first day.

Don't take more than 16mg (eight tablets) on the first day or in the first 24 hours.

Day 2:

- If client felt fine on the total dose taken over the course of the first day, client should take the same dose all at once on the second day.
- If the amount client took on the first day didn't completely control their withdrawal, take an additional 2–4mg (one or two tablets) on the second day.
- If client feels a bit drowsy on the second day, reduce dose by 2–4mg (one or two tablets).
- If client is very sleepy, stop the medication and see prescriber as soon as possible.

Client should see their prescriber within a couple of days of starting buprenorphine.

APPENDIX D - SELF-ASSESSMENT OF OPIOID WITHDRAWAL SYMPTOMS (SOWS)

The SOWS is a self-administered scale for grading opioid withdrawal symptoms. It contains 16 symptoms, the intensity of which the patient rates on a scale of 0 (not at all) to 4 (extremely) and takes less than 10 minutes to complete.

See worksheet on next page.

Patient Instructions: Before taking first dose of buprenorphine, be sure you are in opioid withdrawal. Usually, it takes several hours (12 hours or longer) after last use of an opioid to go into withdrawal. This can take even longer if methadone was taken.

Please score each of the 16 items below according to **how you feel right now**. Circle one number only.

Item	Symptom	Not at all	A little	Moderately	Quite a bit	Extreme
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

TOTAL SCORE: _____

- If score is 17+, it should be safe to take your first dose of buprenorphine.
- If score is 16 or less, wait an hour and then take the test again.

APPENDIX E - SAMPLE BUP/NLX MICRO-DOSING SCHEDULES

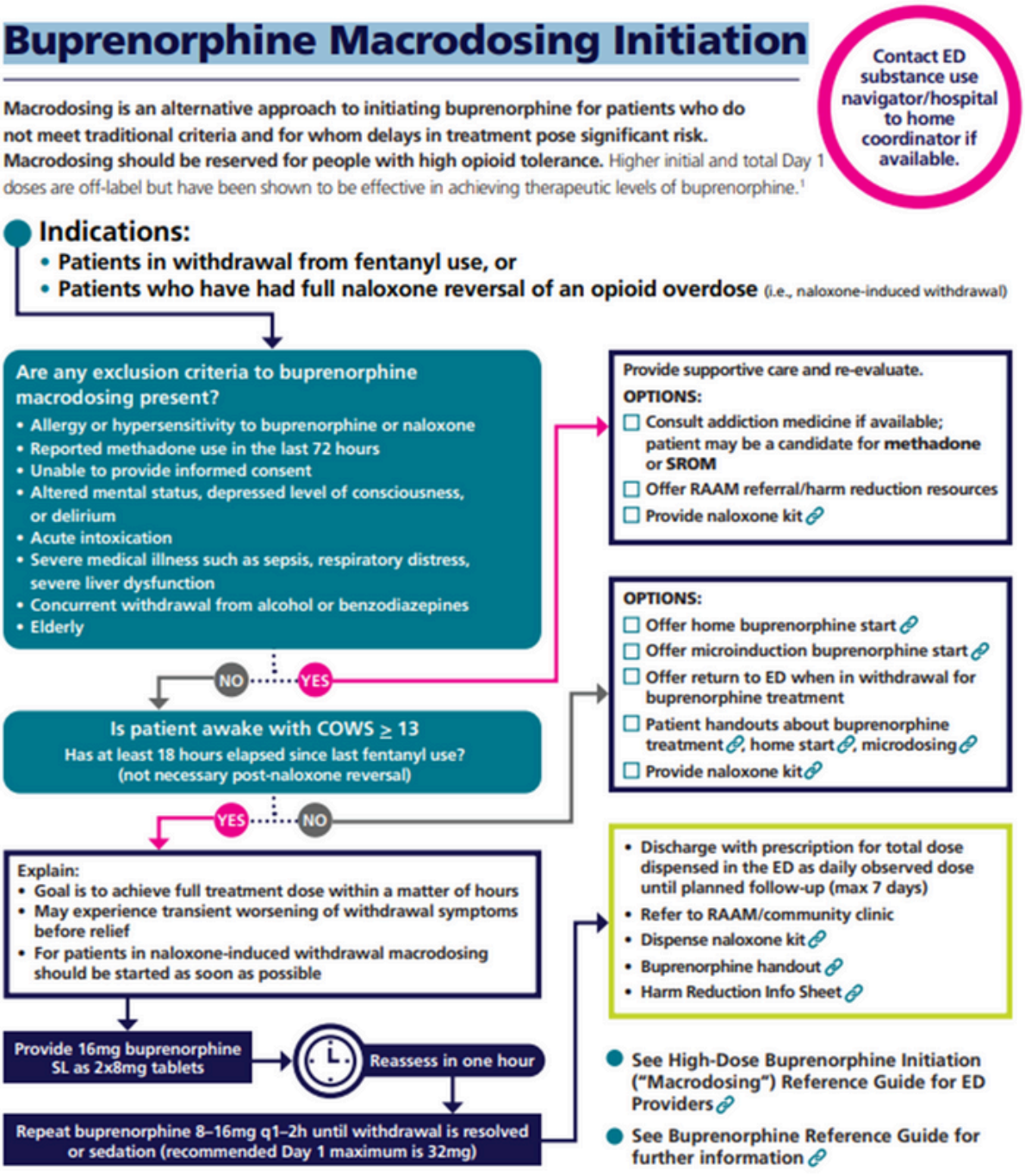
BC Centre for Substance Use (BCCSU) – 7-day Low-Dose Initiation Protocol		
DAY	**BUP/NLX DOSE**	**OTHER OPIOIDS**
1	0.5mg / 0.125mg two times	Continue use
2	0.5mg / 0125mg three times	Continue use
3	1mg / 0.25mg two times	Continue use
4	2mg / 0.5mg two times	Continue use
5	2mg / 0.5mg three times	Continue use
6	4mg / 1mg three times	Continue use
7	12mg / 3mg once	Stop other opioid use

APPENDIX E - SAMPLE BUP/NLX MICRO-DOSING SCHEDULES

BC Centre for Substance Use (BCCSU) – 8-day Low-Dose Initiation Protocol		
DAY	**BUP/NLX DOSE**	**OTHER OPIOIDS**
1	0.5mg / 0.125mg two times	Continue use
2	1mg / 0.25mg two times	Continue use
3	2mg / 0.5mg two times	Continue use
4	3mg / 0.75mg two times	Continue use
5	4mg / 1mg two times	Continue use
6	6mg / 1.5mg two times	Continue use
7	8mg / 2mg two times	Continue use
8	16mg / 4mg once	Stop other opioid use

APPENDIX F - META:PHI RESOURCE FOR MACRO-DOSING INITIATION

Note RAAM is not applicable in Nova Scotia.



APPENDIX G - NS HEALTH PHYSICIAN ORDER SET: BUP/NLX MICRODOSE INITIATION

nova scotia health
Yarmouth Regional Hospital

YR00125604 DOB: Jan/1/1971 AGE: 044Y M
TESTER,TEST
123 STREET P.O.BOX 123
NEW GLASGOW, NS B2H 5C7
Pt. Home Phone: (902)999-9999 UPHI:
FIN CLASS: DOH ING.# EXPIRY:
FD: TEST,DOCTOR 3,BNCWJDBVCJK MDNN
AD: TEST, NONDOCTOR
REG: Jan/8/2015 AJ0000175/14

ORDER SET
Mental Health and Addictions
Buprenorphine/Naloxone Microdose Initiation

Patient: _____ Allergies: _____
Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (❑) are only to be carried out if checked.

Microdosing is an option for initiation of buprenorphine/naloxone not requiring the patient to experience full opioid withdrawal. This method of initiation must be flexible and responsive to the patient's symptoms. Prescribers are encouraged to contact the Addiction Medicine Consult Service for guidance at 1-855-970-0234.

1. **Investigations**
   - ❑ CBC (profile, no diff)
   - ❑ AST, ALT, GGT
   - ❑ Sodium, potassium, calcium, magnesium, phosphate
   - ❑ Creatinine
   - ❑ ECG
   - ❑ Urine drug screen
2. **Monitoring**
   - Monitor for signs and symptoms of opioid withdrawal or signs of excess sedation. Notify prescriber if these occur.
3. **Medications**

❑ **Methadone dose 40 mg/day or LESS**

Day	Buprenorphine/Naloxone Dose	Methadone Dose Guidance	Methadone Dose
1	0.5 mg/0.125 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
2	1 mg/0.25 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
3	2 mg/0.5 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
4	3 mg/0.75 mg SL bid	Taper by 5 to 10 mg (e.g., 30 mg)	Methadone _____ mg po daily
5	4 mg/1 mg SL bid	Taper by 5 to 10 mg (e.g., 20 mg)	Methadone _____ mg po daily
6	5 mg/1.25 mg SL bid	Taper by 5 to 10 mg (e.g., 10 mg)	Methadone _____ mg po daily
7	12 mg/3 mg SL daily	Stop methadone	Methadone 0 mg

❑ **Methadone dose 40 mg/day or MORE**

Day	Buprenorphine/Naloxone Dose	Methadone Dose Guidance	Methadone Dose
1	0.5 mg/0.125 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
2	1 mg/0.25 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
3	2 mg/0.5 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
4	3 mg/0.75 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
5	4 mg/1 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
6	5 mg/1.25 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
7	6 mg/1.5 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
8	7 mg/1.75 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
9	8 mg/2 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
10	9 mg/2.25 mg SL daily	Taper by 10 mg (e.g., 110 mg)	Methadone _____ mg po daily
11	10 mg/2.5 mg SL daily	Taper by 10 mg (e.g., 100 mg)	Methadone _____ mg po daily
12	11 mg/2.75 mg SL daily	Taper by 10 mg (e.g., 90 mg)	Methadone _____ mg po daily
13	12 mg/3 mg SL daily	Taper by 10 mg (e.g., 80 mg)	Methadone _____ mg po daily
14	12 mg/3 mg SL daily	Stop methadone	Methadone 0 mg

Authorized Prescriber's Signature: _____ Reg. No.: _____

Prescriber's Name: _____ Date: _____ Time: _____
Print YYYY/MON/DD HH:MM

AJ0000175/14

Physician Orders
Page 1 of 1 REV 2024/FEB

NSOSMHBNMI

APPENDIX H - PATIENT OAT DECISION AID

COMING SOON

APPENDIX I - OAT DISPENSING FREQUENCY AGREEMENT

Affix patient label here

Opioid Agonist Therapy (OAT)

Dispensing Frequency Agreement

The purpose of this agreement is to ensure the safety requirements around OAT are reviewed and explained by Opioid Recovery Program (ORP) staff and provide space for you to ask questions. Given the risk to you and others, it is important we agree on how to keep everyone safe when taking OAT medication. The points outlined below, as well as your living situation, ability to be regularly assessed, conditions that may impair judgment or safety, medication and substance use interaction and risk, all impact how often you pick up your medications from the pharmacy ("dispensing frequency").

☐ As discussed, you are being prescribed:
- ○ Buprenorphine/naloxone
- ○ Methadone
- ○ Slow-release oral morphine (SROM)
- ○ Other_____

☐ The ingestion of even a small amount of your medication by someone for whom it is not prescribed, especially a child, **could result in overdose, poisoning, or death**. For this reason, OAT medication **must be stored in a secure location** that cannot be accessed by other people or pets.

☐ Participation in **urine drug testing** is expected and you will be asked to provide urine samples.

☐ You will be asked at times to **present to the clinic or your pharmacy with your medication** to ensure that you are taking them as prescribed and storing them securely in an approved container/packaging.

☐ ORP staff have explained:
- The process and reasons for urine drug testing and medication checks.
- If unexpected results occur, a discussion with you and your provider will determine if/how to adjust your treatment plan, prioritizing your goals and safety, and the safety of others.
- What to do if you have concerns about providing samples or medication **within 48 hours** of request,
- The impacts that not being able to complete a UDS / medication check may have on your treatment.

My signature below indicates that I understand and agree to the responsibilities outlined in this agreement, that I have had an opportunity to discuss and review this agreement with someone from the ORP team, and any questions I had have been answered to my satisfaction. **If my situation changes and I can no longer meet these requirements, I understand my dispensing frequency may change.**

Client Signature: _____ ORP Staff Name (print): _____

Date: _____ Date:_____

April 2024: NS Health Form # TBD

Affix COIN barcode labels here