Decision Support Tool

For Registered Nurse Opioid Use Disorder Certified and Registered Psychiatric Nurse Opioid Use Disorder Certified Prescribing of Methadone and Slow-release Oral Morphine

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BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
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ABOUT THIS DECISION SUPPORT TOOL

Intended audience

Developed for registered nurses (RNs) and registered psychiatric nurses (RPNs) who:

- Have completed the Provincial Opioid Addiction Treatment Support Program (POATSP) education and training pathway for Registered Nurses and Registered Psychiatric Nurses from the BC Centre on Substance Use (BCCSU), and
- Meet the competency requirements for methadone and SROM prescribing, and
- Have Registered Nurse Opioid Use Disorder Certified or Registered Psychiatric Nurse Opioid Use Disorder Certified designation with the BC College of Nurses and Midwives (BCCNM), and
- Have authorization from their employer to practice as a Certified Practice Opioid Use Disorder Registered Nurse (CP-OUD RN) or Certified Practice Opioid Use Disorder Registered Psychiatric Nurse (CP-OUD RPN) in their current role.

Purpose

This decision support tool (DST) outlines the activities that are within the scope of CP-OUD RNs and RPNs who are prescribing methadone or SROM for individuals with opioid use disorder (OUD), as well as the situations in which consultation or referral is required.

Using this document

- This document must be used alongside applicable BCCNM scope of practice standards, limits, conditions for CP-OUD RNs and RPNs, and the Guideline for the Clinical Management of Opioid Use Disorder
- Opioid use disorder care should be approached in a manner that is evidence-informed, trauma- and violence- informed, culturally safe, client-centred, and harm reduction-oriented

Definitions

- “Consult” is defined as seeking professional guidance or expertise for a particular concern from a physician (MD) or nurse practitioner (NP) and using this to inform your clinical decisions
- “Refer” is defined as the process in which a CP-OUD RN or RPN hands a client over to an MD or NP as the client’s disease, disorder, or condition is out of their scope of practice

Development

This DST was developed in alignment with the provincial Guideline for the Clinical Management of Opioid Use Disorder by a committee of experts, consisting of partners from the BCCNM, Ministry of Health, Ministry of Mental Health and Addictions, and regional health authorities in BC, and relevant BCCSU staff. Consultation occurred with key stakeholders who supported the scope and definition of the work as well as ensuring the quality of the education and clinical support tools. Reviewers included partners from First Nations Health Authority, Island Health, Fraser Health, Vancouver Coastal Health,

SCOPE OF PRACTICE: METHADONE AND SLOW-RELEASE ORAL MORPHINE

Previously, the scope of practice for CP-OUD RNs and RPNs included continuations, titrations, and restarts of methadone and SROM as opioid agonist treatment (OAT). The new scope expansion allows CP-OUD RNs and RPNs who have completed the education and training for methadone and SROM to initiate these medications for individuals with OUD. If after reviewing this DST, decision-making is still unclear, please consult with an MD/NP or the 24/7 Addiction Medicine Clinician Support Line at 778-945-7619.

Medication	Initiation	Continuations (including missed doses)	Titrations	Restarts (restarting previously prescribed methadone or SROM following 5–30 consecutive days of missed doses)
Methadone	✓ Up to 40mg starting dose	✓	✓	✓
Slow-release oral morphine	✓ Up to 300mg starting dose	✓	✓	✓

METHADONE–WHEN TO CONSULT OR REFER

Doses	Co-occurring Central Nervous System (CNS) Depressant Use	Medications	Pregnancy or Chest-feeding	Severe Hepatic Dysfunction	Abnormal Electrocardiogram (ECG) Results	Youth		Contraindictions	Complex Acute illness or Chronic Disease
						15 or younger	16–18 years of age		
Consult if prescribed over 150mg daily **Refer** for initiation doses greater than 40mg **Refer** for gradual transitions between methadone and SROM **Consult** for rapid transitions between methadone and SROM	**Consult** or **refer** as outlined in Box 5 for prescribed and non-prescribed CNS depressant use (e.g., benzodiazepines, z-drugs, alcohol, opioids) **Prescribed safer supply**: **Consult** if the client is on a prescribed safer supply (e.g., hydromorphone, morphine, sufentanil, fentanyl tablets, or patch) **Co-prescribed SROM: Refer**	**Refer** or **consult** if there is a prescription of new medications with the potential for drug–drug interactions	**Consult** in the absence of a treatment plan from an addiction medicine specialist	**Consult** if GGT or ALT is greater than 3 times the upper limit of normal, or albumin or total bilirubin is outside of the normal range	**Consult** if there are abnormal ECG results (e.g., QTc is greater than 500ms) to determine if alternative OAT should be considered and to determine a plan for follow-up of results *Order ECG if: o Prescription of 2 or more QT-prolonging medications o Pre-existing risk or history is suggestive of possible prolonged QT intervals, such as a family history of sudden cardiac death, family history of prolonged QT syndrome, or personal history of unexplained heart palpitations or arrhythmias	**Refer**	**Consult**	**Consult** if known hypersensitivity to methadone or any component of the formulation, currently taking monoamine oxidase inhibitors (MAOIs), or use within the past 14 days	**Consult** or **refer** if known complex acute or chronic illness outlined in Box 1

* While obtaining an ECG in the above circumstances above is recommended, receiving ECG results and any associated consultations, or the client's inability to get an ECG should not delay the prescription of methadone

Slow-release oral morphine–When to Consult or Refer

Doses	Co-occurring Central Nervous System (CNS) Depressant Use	Medications	Pregnancy or Chest-feeding	Severe Hepatic Dysfunction	Youth		Contraindictions	Complex Acute illness or Chronic Disease
					15 or younger	16-18 years of age		
Consult if prescribed over 1,500mg daily **Refer** for initiation doses greater than 300mg **Refer** for gradual transitions between methadone and SROM **Consult** for rapid transitions between methadone and SROM	**Consult** or **refer** as outlined in Box 5 for prescribed and non-prescribed CNS depressant use (e.g., benzodiazepines, z-drugs, alcohol, opioids) **Prescribed safer supply: Consult** if the client is co-prescribed any prescribed safer supply (e.g., hydromorphone, sufentanil, fentanyl tablet or patch) **Co-prescribed methadone: Refer**	**Refer** or consult for prescription of new medications with the potential for drug–drug interactions	**Consult** in the absence of a treatment plan from an addiction medicine specialist	**Refer** if eGFR is less than 60mL/min/1.73m²	**Refer**	**Consult**	**Consult** if known hypersensitivity to morphine sulfate or any component of the formulation, currently taking MAOIs, or use within the past 14 days	**Consult** or refer if known complex acute or chronic illness outlined in Box 1

PRESCRIBER COLLABORATION

Initiations, Continuations, Titrations, and Restarts

In certain situations outlined in this DST (e.g., client is co-prescribed a CNS depressant), CP-OUD RNs and RPNs are required to consult for initiations, continuations, titrations, and restarts. When an initial consultation with an MD/NP is necessary for some continuations, CP-OUD RNs and RPNs are not required to consult again for continuations if the client's medications and clinical stability remain unchanged. A restart is defined as restarting previously prescribed methadone or SROM following 5–30 consecutive days of missed doses. Missed doses is defined as prescribing when up to 4 consecutive days of methadone or SROM doses have been missed, with dose adjustments required for safety.

OPIOID USE DISORDER

Diagnosis

Clients should have an Opioid Use Disorder (OUD) diagnosis (and associated severity) according to the DSM-5-TR Clinical Diagnostic Criteria for Opioid Use Disorder for CP-OUD RN/RPNs to prescribe OAT.to confirm the diagnosis and assess the severity of OUD.

Registered Nurses and RPNs with CP-OUD are not trained nor authorized to manage chronic pain, and cannot prescribe opioids for pain management. Clients who do not meet the criteria for OUD and are seeking care for chronic pain should be referred to an MD/NP. Registered Nurses and RPNs with CP-OUD may prescribe OAT for individuals with OUD who may also have chronic pain. If the existence of chronic pain makes the diagnosis of OUD unclear, CP-OUD RN/RPNs should consult an MD/NP within organizational pathways, or the 24/7 Addiction Medicine Clinician Support Line at 778-945-7619.

SELECTING OAT

A variety of factors are relevant in selecting OAT. Certified Practice OUD RNs and RPNs should work with each client to determine which medication is best suited, based on their circumstances, goals, and previous treatment experiences.

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo	Potentially slightly better treatment retention than buprenorphine/naloxone	Non-inferior to methadone
Initiation				
Requires withdrawal prior to induction	**Traditional induction:** Yes. Requires moderate withdrawal prior to induction **Low-dose induction:** 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 induction:** (1–3 days) Shorter time to achieve therapeutic dose **Low-dose induction:** (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 buprenorphine/naloxone prior to initiation	N/A	N/A

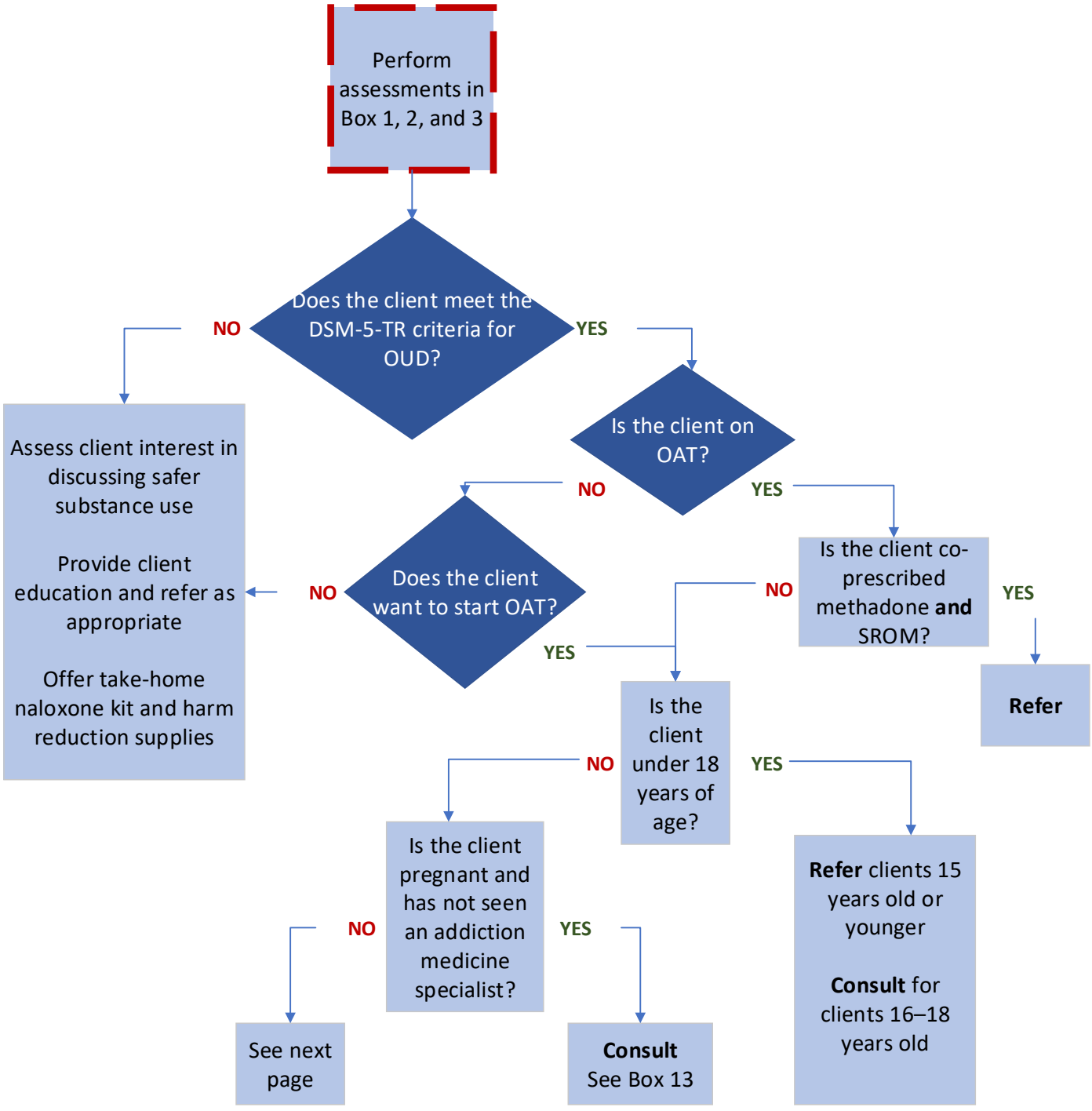
	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants	Low. Due to ceiling effect for respiratory 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
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Risk of precipitated withdrawal during initiation	Yes	No	No	No
Side effects				
Side effects	Milder side effect profile	Medication adverse effects are similar to buprenorphine/naloxone Injection site pain and pruritus	More severe dose-dependent side effect profile (e.g., sedation, weight gain, erectile dysfunction, cognitive blunting)	Comparable to methadone, though less well-described Possibly fewer subjective side effects
Dosing				
Dosing	Health Canada-approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some patients Alternate day dosing possible May be suboptimal for individuals with very high opioid tolerance	First two months: Monthly dose of 300mg. Maintenance dose: Monthly dose of 100mg (though some patients may benefit from remaining at a 300mg maintenance dose)	No maximum dose specified in the product monograph	No maximum dose specified in the product monograph
Take-home doses	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased patient autonomy and cost savings Advantageous for rural and remote locations	N/A	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability

	Buprenorphine-based formulations		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 to buprenorphine/naloxone May be rotated directly to SROM	Risk of precipitated withdrawal when rotating to buprenorphine/naloxone May be rotated directly to methadone
Tapering off				
Tapering off	Milder withdrawal symptoms; easier to discontinue. May be a better option for individuals with lower-intensity physical opioid dependence	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

DECISION SUPPORT TOOL

Start the algorithm at the red dotted box

Screening for Methadone and Slow-release Oral Morphine Prescribing



DECISION SUPPORT TOOL

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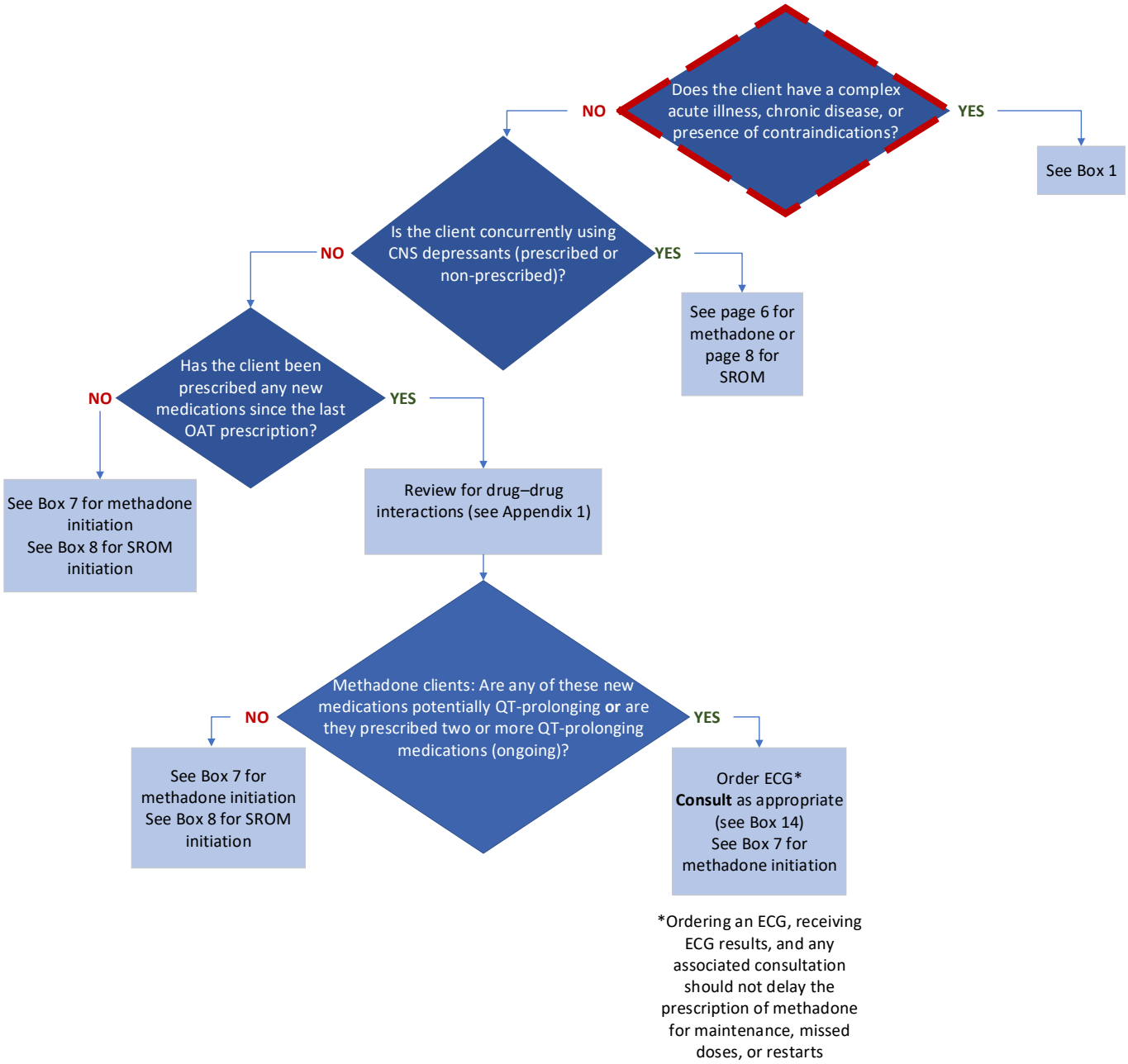
SCREENING FOR METHADONE AND SLOW-RELEASE ORAL MORPHINE PRESCRIBING CONTINUED



DECISION SUPPORT TOOL

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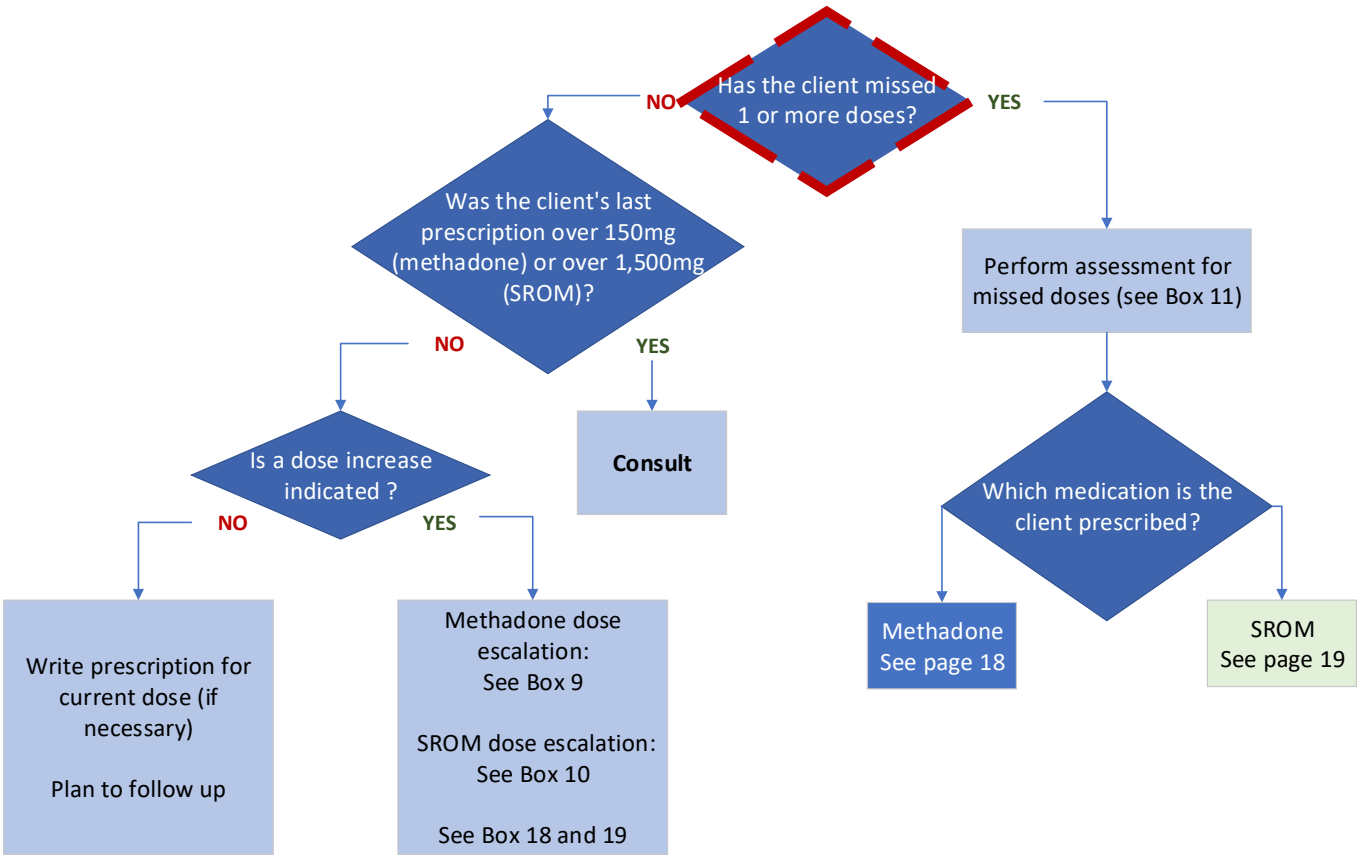
Screening for Methadone and Slow-release Oral Morphine Prescribing Continued



DECISION SUPPORT TOOL

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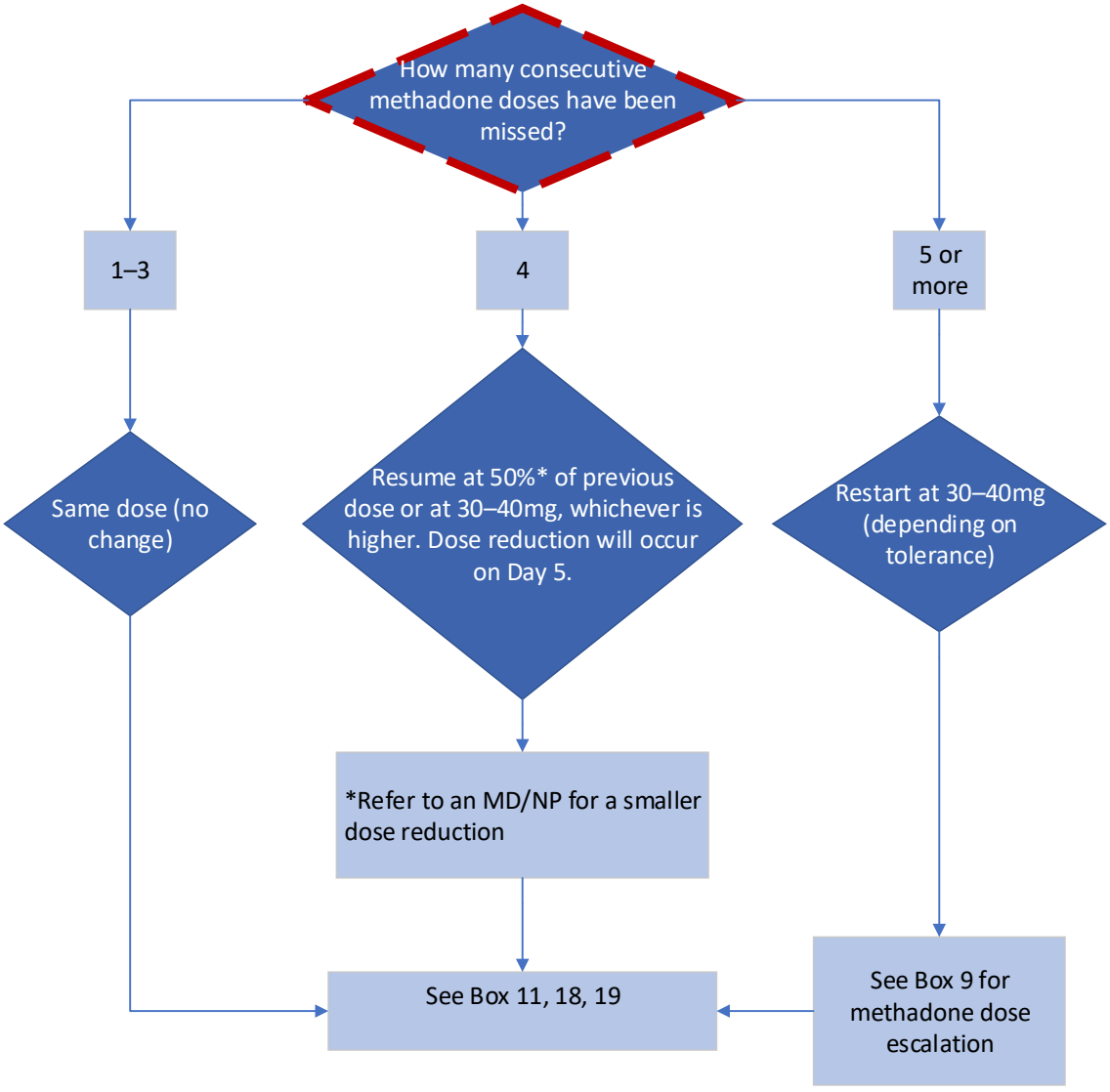
Missed Methadone Doses Protocol



DECISION SUPPORT TOOL

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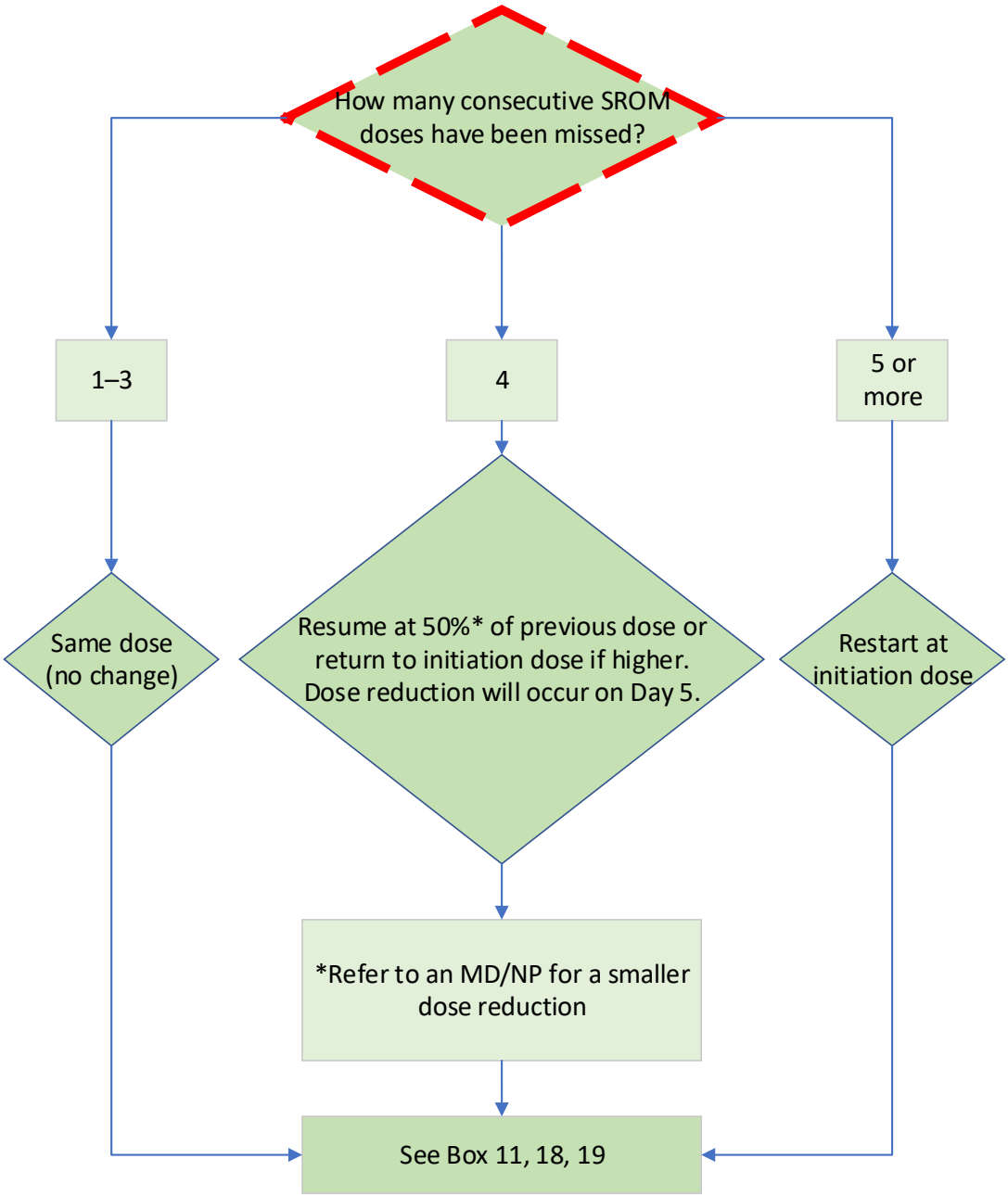
Missed Slow-release Oral Morphine Doses Protocol



NEED TO KNOW

This section provides more detailed information on CP-OUD RNs and RPNs for initiations, continuations, titrations, and restarts – informed by the Guideline for the Clinical Management of Opioid Use Disorder. Additional information regarding when to seek consultation or referral is listed below.

If the client is experiencing clinical instability at any point during your assessment (e.g., unstable vital signs, decreased level of consciousness), they should be referred to an appropriate level of care (e.g., referral to the emergency department in suspected increased intracranial pressure, acute appendicitis, or any presentations that require an immediate assessment). Individuals may also need assessment by an MD/NP for primary care follow-up, which should be facilitated by the CP-OUD RN or RPN.

BOX 1: COMPLEX ACUTE OR CHRONIC ILLNESS ASSESSMENT FINDINGS AND INTERVENTIONS

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
Acute alcohol intoxication or alcohol withdrawal	• Assessment suggestive of alcohol intoxication (e.g., slurred speech, unsteady gait, lack of coordination, reported alcohol use) • Assessment suggestive of alcohol withdrawal (e.g., irritability, tremors, anxiety, diaphoresis) or AUD	If the client is acutely intoxicated, wait until the client is no longer intoxicated and screen for AUD and/or withdrawal symptoms **Consult** for initiations, continuations, titrations, or restarts of methadone or SROM if the client has new alcohol use that exceeds 4 drinks (adult women) or 5 drinks (adult men) on any one occasion **Refer** if the client is experiencing alcohol withdrawal symptoms **Refer** for initiations if the client has AUD **Consult** for continuations, titrations, and restarts if the client has new or worsening AUD
Cardiac compromises such as: • Arrhythmia • Unstable angina • Post-myocardial infarction • Congestive heart failure	• Previous diagnosis by MD/NP • ECG and/or Holter monitoring confirmation • Echocardiogram (ECHO) • Physical assessment suggestive (e.g., irregular heartbeat, dizziness, syncope, crackles or rales, increased edema, or weight gain)	**Consult** for initiations, titrations, or restarts of methadone or SROM, if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or there is a change in the client's presentation

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
Gastrointestinal (GI) conditions such as: • Paralytic ileus (known or suspected) • Bowel obstruction • Suspected surgical abdomen (e.g., acute appendicitis or pancreatitis) • Acute diarrheal illness*	• Previous diagnosis by MD/NP • Confirmed imaging • Physical assessment (e.g., abdominal bloating and distension) • Bloodwork and/or cultures	**Consult** for initiations of methadone or SROM with acute diarrheal illness if the client is clinically stable **Refer** to an appropriate level of care for all other GI conditions *If the client is experiencing acute diarrheal illness, assess for opioid withdrawal
Severe respiratory compromises such as: • Acute asthma • Pneumonia • Chronic obstructive pulmonary disease (COPD) exacerbation	• Previous diagnosis by MD/NP • Diagnostic pulmonary function tests • History of hospitalization for COPD • Rapid respiratory rate (>20 breaths per minute) • Decreased oxygen saturation (<92% SpO2) • Increased work of breathing (e.g., tripod, unable to speak in full sentences) • Decreased air entry • Wheezing upon auscultation	**Consult** for initiations of methadone or SROM, if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or there is a change in the client's presentation
Severe hepatic compromises such as: • Cirrhosis • Hepatocellular carcinoma • Acute hepatitis • Liver failure	• Previous diagnosis by MD/NP • Evidence on computed tomography (CT), FibroScan, or ultrasound • Abnormal liver enzymes: If GGT or ALT are over 3 times the upper limit of normal, or albumin or total bilirubin are outside of the normal ranges	**Consult** for initiations of methadone or SROM, if clinically stable **Refer** for acute hepatitis or liver failure or if the client displays signs of clinical instability or there is a change in the client's presentation
Sepsis	• Previous diagnosis by MD/NP • Physical assessment (e.g., febrile, dizziness, change in mental state) • Abnormal bloodwork (e.g., elevated white blood cells) • Abnormal imaging suggesting infection	**Refer** to an appropriate level of care if the client displays signs of clinical instability

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
Severe CNS compromises such as: • Brain tumor • Recent head injury • Increased intracranial pressure	• Previous diagnosis by MD/NP • Neurological and physical assessment (e.g., new onset of severe headache, blurred vision, acute confusion and memory loss, nausea and vomiting, difficulties walking or speaking) • Unstable vital signs • Abnormal imaging or tests (e.g., X-ray, CT, magnetic resonance imaging [MRI], lumbar puncture)	**Consult** for initiations of methadone or SROM if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or change in the client's presentation
Seizure disorder or epilepsy	• Previous diagnosis by MD/NP • Seizure disorder confirmed by electroencephalogram (EEG) • History of seizures • Anti-convulsant medication for the treatment of seizures	**Consult** for initiations of methadone or SROM, if clinically stable **Refer** if the client displays signs of clinical instability or there is a change in the client's presentation

BOX 2: CLIENT ELIGIBILITY

1. Presence of opioid use disorder
2. Informed consent
3. No contraindications for methadone or SROM, severe chronic or acute disease, allergy or hypersensitivity, severe respiratory distress, delirium tremens, or acute alcohol intoxication

BOX 3: CLIENT ASSESSMENT BEFORE PRESCRIBING

1. Obtain informed consent to perform an assessment
2. **Reminder**: Certified Practice OUD RNs and RPNs must assess the client in-person or through virtual care with a visual assessment
    - If a visual assessment is not possible, CP-OUD RNs and RPNs can only prescribe to known clients and/or clients that have been assessed in person by another health care provider
3. Conduct a Best Possible Medication History (BPMH) and PharmaNet review
    - Confirm if there is a current OAT prescription
    - If applicable, contact the care provider from the most recent OAT prescription to ensure collaboration and appropriate communication
        - This should not delay the OAT prescription
        - The client's regular prescriber may want to follow up with the client at a later date
        - Consider sending an encounter note to maintain open communication pathways

- Review for current prescription of safer supply
  - **Consult** if the client is currently prescribed safer supply by another provider
- Determine whether any new medications have been prescribed since the last OAT prescription
  - **Consult** or **refer** as appropriate if medication/allergy contraindications or drug–drug interactions are identified during the BPMH and PharmaNet review (see Appendix 1 and UpToDate)
- Methadone: **consult** if the client is prescribed a new QT-prolonging drug

4. Review substance use and past medical history with the client
5. Conduct physical assessment as needed
6. Assess the client's goals
   - Including treatment goals, current housing, income, social support, and legal support
   - Connect with the health care team or refer as appropriate
7. Offer lab tests (see Appendix 2)
   - Note that continuation of OAT should not be delayed while waiting for bloodwork
   - Urine drug test, when clinically indicated (see Box 6)
   - Pregnancy test, where appropriate (see Box 13)
   - Methadone: ECG, when clinically indicated (see Box 14)
8. Assess for new complications, particularly:
   - Methadone: severe hepatic dysfunction
   - Slow-release oral morphine: renal dysfunction
9. Review medication coverage

BOX 4: CLIENT EDUCATION

Prior to initiation, discuss treatment options, including the risks and benefits of treatment, and potential side effects and relevant drug–drug interactions.

Harm Reduction

1. Education on safer use practices to help prevent drug poisoning
   - Avoid using alone
   - Use a local supervised consumption site or drug poisoning prevention site
   - Use the Lifeguard app
   - Use a small amount of drugs to start (i.e., a "test dose)
   - Use drug-checking services, if available
   - Risks of co-occurring substance use, including CNS depressant use or stimulants
2. Take-home naloxone
   - If a kit cannot be provided at the time, provide information on where to acquire one
   - Offer education and training on take-home naloxone for the client and any relevant support people (e.g., family, friends, support staff)
3. Harm reduction supplies
   - Offer safer use supplies and related education to support infection prevention (e.g., bacterial, HIV, HBV/HCV)
4. Information on available community resources as required or requested

BOX 5: CONCURRENT CNS DEPRESSANTS

If the client is taking central nervous system depressants (prescribed or non-prescribed), such as benzodiazepines, z-drugs, opioids, or alcohol:

1. **Consult** for initiations, continuations, titrations, and restarts for clients with new alcohol use that exceeds 4 drinks (adult women) or 5 drinks (adult men) on any occasion in the past year, or other new central nervous system depressant use
2. **Consult** for continuations, titrations, and restarts if:
   - The client is clinically unstable, as demonstrated by increased sedation or increased risk of drug poisoning, or
   - Central nervous system depressant use has changed significantly in terms of substance, frequency, and/or dose, or if the client has new or worsening AUD
3. **Refer** for initiations if the client has a sedative use disorder or AUD
4. **Refer** if the client displays alcohol withdrawal symptoms

BOX 6: URINE DRUG TESTING

1. When performing a UDT, CP-OUD RNs and RPNs should follow Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment–Breakout Resource
2. Urine drug testing should be used when the results may impact the treatment plan, and should not be used punitively

When to perform UDT (methadone or SROM):

Treatment	UDT schedule
Initiation, titration, and stabilization	• Monthly or more or less frequently • In circumstances where UDT is occurring less than monthly, client safety can be increased with DWI
Maintenance	• When clinically indicated
Take-home doses	• The frequency of scheduled UDT is as required when clinically indicated

Reminder (SROM-specific): A positive hydromorphone UDT result does not necessarily indicate that hydromorphone has been taken

- **Morphine is metabolized to hydromorphone and codeine by a minor pathway**
- **With low doses of morphine, the amount of hydromorphone may not be detectable**
- **Clients who are prescribed SROM for OUD are prescribed relatively high doses, which can lead to concentrations of hydromorphone well above the cut-off being detected in their urine**
- While confirmatory testing is an option, a conversation with the client should be had if there are concerns

Missed doses

- A UDT negative for prescribed medication indicates that the client has missed doses
- A pattern of negative tests for the prescribed medication and positive for unexpected substances may indicate the need for treatment plan adjustments such as:
  - Discontinuation or reduction of take-home doses
  - Increased psychosocial interventions and support
  - A higher level of care (e.g., more frequent appointments, increased psychosocial support)
  - Increased client education
  - A dose increase
  - Trialing a different OAT medication

BOX 7: METHADONE INITIATION

1. Methadone initiation doses are dependent on the client's level of tolerance
2. Certified Practice OUD RNs and RPNs must **refer** clients to an MD/NP for initiation methadone doses greater than 40mg

Level of Tolerance	Suggested Starting Dose
No tolerance | opioid-naive High risk of toxicity Includes clients who have completed withdrawal management, those not currently using opioids but at risk of relapse, clients with heavy use of other sedating agents, and clients with severe comorbidities that affect toxicity risks	5–10mg/day
Unknown tolerance Moderate risk of toxicity Includes clients who use benzodiazepines or other sedatives (prescribed or non-prescribed), clients with severe alcohol use disorder	10–20mg/day
Known tolerance Lower risk of toxicity Clients actively using opioids	20–30mg/day
Known tolerance Lower risk of toxicity Characterized specifically by previous methadone use and current fentanyl use	30–40mg/day*

*Close monitoring should be arranged for those receiving higher starting doses, based on the clinician's discretion and client history with OAT. **Refer** to MP/NP if the client requires an initiation dose outside of this range.

BOX 8: SLOW-RELEASE ORAL MORPHINE INITIATION

1. Slow-release oral morphine initiation doses are dependent on the client's tolerance
2. Certified Practice OUD RNs and RPNs must **refer** clients to an MD/NP for initiation doses greater than 300mg

Level of Tolerance	Suggested Starting Dose
No/low tolerance | opioid-naïve High risk of toxicity Includes individuals who have completed withdrawal management, those not currently using opioids but at risk of relapse, individuals with heavy use of other sedating agents, and those with severe comorbidities that affect toxicity risks	50mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes individuals who use benzodiazepines or other sedatives (prescribed or non-prescribed) and individuals with alcohol use disorder.	100–150mg/day
Known tolerance Lower risk of toxicity Clients actively using opioids	200 mg/day
Known very high tolerance Very low risk of toxicity Characterized specifically by previous SROM use and current fentanyl use	300 mg/day*

*Close monitoring should be arranged for those receiving higher starting doses, based on the clinician's discretion and client history with OAT. Refer to MD/NP if the client requires an initiation dose greater than 300mg/day.

BOX 9: METHADONE DOSE ESCALATION

1. An assessment, either in-person or virtual, must be done prior to a dose escalation
2. Certified Practice OUD RNs and RPNs must **consult** for daily doses greater than 150mg

Level of Tolerance	Recommended Dose Escalation
Unknown tolerance or no history of OAT with methadone	5–10mg every 3–5 days
Established high opioid tolerance (i.e., documented active fentanyl use) and experience with methadone in the past year	Maximum of 15mg every 3–5 days Once the daily dose reaches approximately 85mg, the titration process should be slowed to a maximum of 10mg every 3–5 days

BOX 10: SLOW-RELEASE ORAL MORPHINE DOSE ESCALATION

1. An assessment, either in-person or virtual, must be done prior to a dose escalation
2. There is no defined maximum dose for SROM; however, CP-OUD RNs and RNs must **consult** if the total daily dose plus dose increase exceeds 1,500mg

Client Presentation	Dose Escalation
• Tolerated the previous dose, as demonstrated by no drowsiness post-dose. • Requires a dose increase, as demonstrated by the client experiencing: o Cravings o Withdrawal symptoms o Ongoing non-prescribed opioid use o Monitor the client frequently until stable	• Increase by up to 100mg every 24–48 hours

BOX 11: ASSESSING CLIENTS WHO HAVE MISSED DOSES

1. Review BPMH and PharmaNet
2. Ask the client if they have missed OAT doses
   - If the client reports missing doses, empathetically ask the client why they have missed doses
   - Clients who report missed doses may require additional support (e.g., consider take-home dosing if DWI is a barrier due to employment or school)
3. Ask the client about any ongoing substance use
4. Conduct UDT, if appropriate
5. Document findings
6. Inform other members of the client's care team
7. Clinicians should address missed doses on a case-by-case basis
8. Discuss whether the current treatment continues to be the best option for the client
   - If the client would like to start buprenorphine/naloxone, go to Decision Support Tool For Registered Nurse Opioid Use Disorder Certified and Registered Psychiatric Nurse Opioid Use Disorder Certified Prescribing of Buprenorphine/naloxone
   - Gradual transitions between SROM and methadone are out of scope for CP-OUD RNs and RPNs, **refer** to an MD/NP
     - Gradual transitions may be suitable for clients who are not using unregulated opioids
   - Rapid transitions between SROM and methadone require **consultation** with an MD/NP, and the ratio should be discussed in consultation with the MD/NP
     - Rapid transitions may be suitable for clients with a higher opioid tolerance
9. Communicate with the original OAT prescriber, if applicable
   - The OAT prescription should not be delayed if unable to contact the OAT prescriber
10. Follow missed doses protocol (see page 18 for methadone and page 19 for SROM)
11. Follow up frequently until the client is stabilized (see Box 19)
12. **Reminder**: Certified Practice OUD RNs and RPNs must prescribe within their scope
    - Bridging prescriptions without an assessment of the client is out of scope for CP-OUD RNs and RPNs
    - Pharmacists may be consulted to complete their assessments to extend/renew current prescriptions or initiate emergency prescriptions

BOX 12: CONSIDERATIONS FOR YOUTH

1. In caring for youth, CP-OUD RNs and RPNs must have competence not only related to prescribing medications for the client but other considerations such as obtaining consent and related legislation, such as the Infants Act
2. When prescribing, the Treatment of Opioid Use Disorder for Youth–Guideline Supplement and the Guideline for the Clinical Management of Opioid Use Disorder should guide care
   - Youth aged 16–18 years: **consult**
   - Youth aged 15 years or younger:
     - **Refer** to another provider
     - Provide other interventions within scope:
       - Safety planning, provision of harm reduction supplies and education, relationship building, connection to health care services, and provision of a safe space to discuss the client's wellbeing

BOX 13: CONSIDERATIONS FOR PREGNANCY

1. All clients of childbearing capacity who are sexually active and are considering starting or restarting methadone or SROM should be offered a pregnancy test
   - Note that a pregnancy test is not required to prescribe methadone or SROM
2. Certified Practice OUD RNs and RPNs can continue methadone or SROM prescriptions for clients who are pregnant but should ensure these clients are being followed for perinatal and primary care
   - Where possible, these may be arranged through organizational consultations
3. **Consult** an addiction medicine specialist through the 24/7 line or through their organizational pathway in the absence of a treatment plan from an addiction medicine specialist
4. Certified Practice OUD RNs and RPNs may **consult** the 24/7 line at any point for questions about pregnant clients and OAT and substance use care
5. Further guidance can be found in the Treatment of Opioid Use Disorder Pregnancy–Guideline Supplement

BOX 14: ELECTROCARDIOGRAM (METHADONE)

1. Ordering an ECG, receiving ECG results, and any associated consultation should not delay the prescription of methadone for maintenance, missed doses, or restarts

When to order an ECG:

- New prescription of QT-prolonging medications (see Appendix 1)
- Prescription of 2 or more QT-prolonging medications
- Pre-existing risk of prolonged QT interval (e.g., syncope, arrhythmias, history of cardiac disease, or family history of sudden cardiac death)

Managing results:

- **Consult** if ECG is abnormal or if QTc is 500ms or greater
  - The CP-OUD RN or RPN will be advised on how to proceed with the methadone prescription
- An abnormal ECG should not delay the prescription of methadone
  - It may indicate a health concern unrelated to OAT
- **Refer** to primary care or ED for workup for abnormal ECG results in a timely manner based on the client's presentation
- Consultation options include the original OAT provider, primary care MD/NP, or 24/7 line

BOX 15: TAKE-HOME DOSES

1. When prescribing take-home methadone or SROM doses, CP-OUD RNs and RPNs should follow the Guideline for the Clinical Management of Opioid Use Disorder
2. Take-home doses of methadone and SROM should start as individual non-consecutive doses (i.e., clients should not have take-home doses on back-to-back days)
   - A UDT negative for other opioids or other substances is not required
3. Before the provision of take-home methadone or SROM doses, the following client criteria should be met:
   - A minimum of 4 continuous weeks on methadone or SROM
   - Evidence of medication adherence
   - Clinical and psychosocial stability
   - Confirmed by attending all scheduled appointments, having no frequent missed doses or appointments, improved social relationships, or returning to work or school
   - Ability to safely store medication at home
4. Additional take-home doses can be offered gradually (e.g., every 2 weeks) to those who have consistently managed their take-home doses, sustained medication adherence, and continue to experience clinical and psychosocial stability including a reduction in substance use

Methadone and SROM Take-home Dosing Protocol

Number of Consecutive Take-home Per Week	Minimum Time on Methadone/SROM	Conditions/Criteria
0	–	Any of: • Inability to safely store medication • Unstable psychiatric illness or other acute mental health crisis • Frequent missed doses and appointments • Ongoing high-risk or uncontrolled substance use patterns
1–3 (non-consecutive take-home doses)	4 weeks	All of: • Ability to safely store medication (e.g., secure, locked containers or cabinets) • Evidence of medication adherence (e.g., UDT positive for methadone) • Clinical and psychosocial stability, including: o No frequent missed doses or appointments o No acute behavioral or psychiatric issues at the point of assessment o No high-risk or uncontrolled substance use patterns that cause frequent drug poisonings, blackouts, or other severe safety risks

Number of Consecutive Take-home Per Week	Minimum Time on Methadone/SROM	Conditions/Criteria
4–6 (consecutive take-home doses)	12 weeks	All of: • Consistent medication adherence with rarely missed doses and appropriate management of non-consecutive take-home doses • Improved clinical and psychosocial stability, including: o Rarely missed appointments o Minimal unprescribed substance use, in alignment with the treatment plan and client goals, with no recent drug poisonings or blackouts

BOX 16: CONSIDERATIONS FOR INITIATING TAPER

The evidence on OAT tapering is lacking

1. Due to the high likelihood of clients returning to unregulated opioid use, OAT tapers are generally not recommended
2. However, if the client requests a taper following a sustained period of stability on OAT (12 months or more), then a gradual tapering regimen over months to years is recommended
3. If a client requests a methadone or SROM taper:
   - **Consult** an MD/NP
   - Provide education and listen empathetically to the client's concerns and reasons for wanting a taper
     - As appropriate, counsel the client on the risks of returning to substance use and drug poisoning
     - Offer information on harm reduction strategies including access to take-home naloxone
   - Offer support and referrals to appropriate services
   - Encourage the client to connect with their prescriber if concerns about substance use arise
   - A relapse prevention plan should be collaboratively developed and implemented after a discussion with the client

BOX 17: MEDICATION SHORTAGES (SROM)

1. In the past, there have been temporary shortages of specific strengths of SROM—brand name Kadian (24-hour formulation)
2. For reports about current drug shortages, visit Drug Shortages Canada
3. In the event of a medication shortage, visit the Province of British Columba's Drug Shortages page for updates on pharmacy-related products
   - General management steps include:
     - Contact the client, determine a treatment plan, and document it in the client's medical record
     - The usual course of action is to switch to sustained-release oral morphine (12-hour formulation; M-Eslon) in the short term
   - Discuss with the client that conversion to M-Eslon is temporary and that they will be transitioned back to Kadian once the shortage resolves

Converting clients to M-Eslon:

1. Cancel existing SROM prescription
2. Prescribe M-Eslon
   - Note that M-Eslon is the same therapeutic dosage as SROM, but will be divided into 2 doses
   - For example, 1,000mg of SROM per day is equivalent to 500mg M-Eslon twice daily
3. For individuals on DWI of SROM, the first dose will generally be DWI, while the second dose may be a take-home dose
   - Prescribers can consider witnessing of the second dose and indicate this on the prescription; however, take into consideration the hours of the pharmacy and logistics for the client
4. Write the duplicate and include the note: "Cancel the previous prescription for SROM and replace with M-Eslon 500mg BID
5. Convert them back to once daily Kadian once shortage resolved. No dose adjustments are needed

BOX 18: DOCUMENTATION

Documentation when following this decision-making tool should include:

- Adherence to BCCNM Documentation Standards
- Baseline assessment, BPMH, and PharmaNet review
- Medication (e.g., prescribed, dispensed, administered) to include indication, formulation, dose, frequency, duration, route of administration, and client education
- Follow-up plan
- Other relevant information for the care team
- Any consultation or referral done concerning the client's care
- The rationale for prescribing decisions

Example SOAP note**:**

1. Subjective
   - Client report including:
     - Substance use and treatment history
     - Reasons for the missed dose(s)
     - Symptoms and mood
   - Collateral information from the team or family
2. Objective
   - Best Possible Medication History and PharmaNet review
   - Lab test results and POC results if applicable (including UDT)
   - Vital signs
   - Take-home doses: monitoring (e.g., UDT)
   - Client's general appearance (e.g., acutely intoxicated, injection marks, diaphoresis, tremors)
3. Assessment
   - Clinical impression and diagnosis (e.g., opioid use disorder: client unstable as evidenced by ongoing unregulated opioid use)
4. Plan
   - Consultation related to the client's care
   - Treatment plan:
     - Interventions: medications dispensed, administered, or prescribed, including full order information drug name/formulation, dose, route, frequency, indication, and length of prescription
     - The treatment plan for resuming medication after missed doses
     - Take-home doses: rationale to initiate or revise take-home doses, confirmation the client criteria have been met
     - Any referrals
   - Client education and other interventions as appropriate
   - Follow-up plan
   - Any changes such as increased doses, decreased doses, or missed doses must be documented on PharmaNet using the transaction medication update (TMU) by end of the clinic day or shift, if the facility has implemented the Integrated Interdisciplinary Model of OAT (IIMOAT)

BOX 19: STABILIZATION AND FOLLOW UP

Clinical follow-up appointments

1. Continue to assess the client every 1–2 weeks once the client is stabilized on methadone or SROM
   - Consider decreasing follow-up visits to every 2–4 weeks and then monthly as increased clinical stability is achieved
2. Follow-up assessments should include:
   - Adequacy of dosage (e.g., client report of withdrawal symptoms or cravings)
   - Adverse effects
   - Review of drug–drug interactions (see Appendix 1 and UpToDate)
   - Substance use (via client report and, when indicated, UDT)
   - Client goals and support for these goals
   - Physical and mental health
   - Psychosocial domains, as clinically indicated
     - Including housing, relationships, and finances
   - Education about harm reduction and safer injection practices, as clinically indicated
   - Offering referrals to appropriate services as needed
   - Health promotion
3. Urine drug tests should be done at clinician's discretion when the results may impact the treatment plan
4. Evidence of other non-medical opioid use or other substance use should prompt a reassessment of the treatment plan, but not automatic discontinuation of take-home doses
   - Non-medical opioid use or other substance use to address withdrawal and cravings may indicate that a higher dose is needed
5. For clients prescribed take-home methadone or SROM showing signs of major instability, individual client circumstances should be considered
   - Appropriate responses may include:
     - Increasing the frequency of clinical appointments in order to provide more intensive support, monitoring, and assessment
     - Reassessing dose, especially if the client is reporting cravings or withdrawal
     - Providing referrals to adjunct psychosocial and community-based supports, as appropriate
6. For clients prescribed take-home methadone or SROM showing signs of major instability, individual client circumstances should be considered
7. If doses have been missed, follow missed doses protocol (See Box 11)

BOX 20: ACTING ON A CERTIFIED PRACTICE OUD RN OR RPN'S ORDER

1. In some health care settings where methadone/SROM is ward stock, prescribing, dispensing, and administering methadone/SROM may occur
2. Certified Practice OUD RNs and RPNs are authorized to give client-specific orders that other nurses (LPNs, RNs, RPNs) are permitted to act on for dispensing or administering methadone or SROM

BOX 21: SAFETY CONSIDERATIONS

1. Prescribers are encouraged to inform and remind their clients that they should not drive or operate heavy machinery while intoxicated or sedated by any substance, including during OAT initiation and dose increases. Refer to A Guideline for the Clinical Management of Opioid Use Disorder for more information.
2. Methadone generally reaches a steady state after approximately 5 days of continuous use, clients should be advised against driving during the first 5 days of a dose increase
3. SROM reaches a steady state after 24–48 hours of continuous use; clients should be advised against driving during the first 2 days of a dose increase
4. Clinicians are obligated to report clients who have continued to drive, against clear clinician advice, if they have a medical condition that, in the clinician's opinion, makes it dangerous to drive
    - Includes active substance use disorders that would affect safe driving
    - See Canadian Council of Motor Transport Administrators Medical Standards
5. Follow organizational and employer policies, and contact risk management lead as appropriate
6. Certified Practice OUD RNs and RPNs are encouraged to consider the following policies, standards, bylaws, and resources:
    - The BCCNM Privacy and Confidentiality Practice Standard
        - If nurses are concerned that a client poses a risk of harm to themselves or others, report it immediately to an appropriate person and follow any relevant organizational policies, procedures, or restrictions.
    - The BCCNM Bylaw 183 Disclosure of Client Personal Information
        - A registrant must maintain confidentiality of personal information about a client, and may disclose personal information about a client only:
            - ◊ If the registrant believes on reasonable grounds that there is a risk of significant harm to the health or safety of any person and that the use or disclosure of the information would reduce that risk
    - Organizational and employer policies
        - Certified Practice OUD RNs and RPNs can consult an MD/NP for guidance if needed within organizational pathways and discuss concerns with leadership and risk management, if applicable

APPENDIX 1

Drug-drug interactions

It is the responsibility of the CP-OUD RN and RPN to stay up to date with drug–drug interactions (e.g., by using UpToDate or other approved reference material).

Common drug–drug interactions		Comment	Action for CP-OUD RN and RPN
Category	Examples		
Alcohol	Medications containing alcohol (e.g., liquid formulations of cold medicine)	The additive depressant effect increases the risk of respiratory depression, profound sedation, coma, and death	**Consult** if there has been new use since the last prescription **Consult** if there is ongoing use and the client is clinically unstable (e.g., increased sedation, intoxication) if CNS depressant use has changed significantly in terms of substance, frequency, or dose, and prioritizing client safety See Box 1 for alcoholic beverage use or AUD
Central nervous system depressants	Anti-emetics Anti-histamines Anti-psychotics Anxiolytics Muscle relaxants Neuroleptics Other opioids Phenothiazines Sedatives/hypnotics Benzodiazepines Z-drugs Tranquilizers	The additive depressant effect increases the risk of respiratory depression, profound sedation, coma, and death	**Consult** for initiations, continuations, restarts, or titrations if new use or significant changes in client's status. **Refer** for initiations if the client has a sedative use disorder
Diuretics	Acetazolamide Amiloride Bumetanide Chlorthalidone Ethacyrnate Furosemide Indapamide Hydrochlorothiazide Metolazone Spironolactone Triamterene	SROM Morphine reduces the efficacy of diuretics by inducing the release of antidiuretic hormone Morphine may also lead to acute retention of urine by causing spasms of the sphincter of the bladder, particularly in people with prostatism	**Consult** if uncertain or the client is experiencing urine retention

Common drug–drug interactions		Comment	Action for CP-OUD RN and RPN
Category	Examples		
Opioid antagonists	Naltrexone	**Contraindicated** Blocks the pharmacological effects of methadone and SROM, which can lead to precipitated withdrawal	**Consult** the original prescriber of naltrexone
Mixed agonists/ antagonists, and partial agonists	Buprenorphine	**Contraindicated** Blocks the pharmacological effects of methadone and SROM, which can lead to precipitated withdrawal	Discuss the treatment plan with the client **Consult** the original prescriber of the medication **Low-dose buprenorphine/ naloxone induction** This is the only circumstance where methadone and SROM may be co-prescribed with buprenorphine/naloxone
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine Tranylcypromine	**Contraindicated** May increase the risk of serotonin syndrome	**Do not** prescribe methadone or SROM for individuals who have received MAOI in the previous 14 days **Consult** another provider with addiction medicine experience for support with clinical management
CYP3A4 inhibitors	Macrolide antibiotics (e.g., azithromycin, clarithromycin, erythromycin) Azole antifungals Protease inhibitors (antiretroviral therapy)	Methadone May require methadone dose reduction or a change in antibiotic, antifungal, or protease inhibitor	**Consult** before prescribing in the absence of a documented plan for the methadone prescription Closely monitor client Contact the antibiotic or antifungal prescriber if a change is required

Common drug–drug interactions		Comment	Action for CP-OUD RN and RPN
Category	Examples		
CYP3A4 inducers	Carbamazepine Phenytoin Rifampicin/rifampin	May result in under-treatment of opioid use disorder Methadone May require dose adjustment of CYP3A4 inducer or methadone	Closely monitor client **Consult** pharmacy or other resources before prescribing if uncertain **Discontinuation of CYP3A4-inducer medication** If the medication is discontinued, it can lead to abrupt increases in serum levels and possible toxicity **Change in medication** Contact the prescriber if a change in CYP3A4-inducer medication is required
Serotonergic medications	**SSRIs** • Citalopram • Escitalopram • Fluoxetine • Fluvoxamine • Paroxetine • Sertraline • Vilazodone **SNRIs** • Desvenlafaxine • Duloxetine • Levomilnacipran **Tricyclic Antidepressants** • Amitriptyline • Amoxapine • Nortriptyline	May increase the risk of serotonin syndrome	Be aware of the symptoms of serotonin syndrome Follow up with the client after the first methadone or SROM dose adjustment Assess for: ○ Mood alteration ○ Agitation, anxiety, disorientation, excitement, or restlessness ○ Neuromuscular excitation ○ Tremors, clonus, hyperreflexia, muscle rigidity, bilateral Babinski signs, and akathisia ○ Autonomic dysfunction ○ Diaphoresis, flushed skin, hyperactive bowel sounds **Consult** if any symptoms arise or if uncertain

Common drug–drug interactions		Comment	Action for CP-OUD RN and RPN
Category	Examples		
Methadone Potentially arrhythmogenic agents (See UptoDate)	Class I and III anti-arrhythmics Some antipsychotics Some calcium channel blockers Diuretics and laxatives (due to potential electrolyte disturbance	These medications have the potential to prolong the QT interval	**Consult** if QTc is over 500ms An abnormal ECG should not delay the prescription of methadone **Refer** to primary care or ED for workup for abnormal ECG results in a timely manner based on the client's presentation **Reminder**: A telephone consultation may not be sufficient as the provider providing guidance will require collateral information to contextualize the ECG results

APPENDIX 2

Summary of Laboratory and Point-of-Care Tests CP-OUD RNs and RPNs are Authorized to Order

Laboratory Test	Follow-up for CP-OUD RNs and RPNs
Tests Performed Before Initiating OAT If performing prior to initiation presents a barrier to care, these tests should be ordered as soon as reasonably possible	
Urine–Immunoassay urine drug test Either POC or lab-tested immunoassay	• To confirm client-reported substance use and prescribed medication • False-positives and false-negative results are possible for opioids and benzodiazepines, and false-positive results are possible for amphetamines • See Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment: Breakout Resource for more information; can consult within your organization or 24/7 line
Pregnancy test	• A pregnancy test should be performed on clients of child-bearing capacity and who are sexually active, to ensure the client is connected to appropriate follow-up care and to guide the treatment plan • **Consult** in the absence of a documented plan from a (perinatal) addiction medicine specialist
Tests to be Offered Every 12 Months These tests should not be a barrier to resuming prescriptions	
Blood Complete blood count Creatinine—serum/plasma Renal function–eGFR Prothrombin time/INR	**Consult** an MD/NP if outside the normal ranges as per organizational processes to determine a plan of care Slow-release oral morphine **Refer** if less than 60mL/min/1.73m^2
Liver function Albumin Alanine aminotransferase Bilirubin	Methadone **Consult** before prescribing methadone if albumin is abnormally low, ALT is over 3 times the upper limit of normal, or if bilirubin is elevated An abnormal liver function under 3 times the upper limit of normal should not delay the prescription of methadone, but the client should be connected to primary care for follow up

Laboratory Test	Follow-up for CP-OUD RNs and RPNs
Tests to be Offered as Clinically Indicated	
ECG (methadone only)	**Consult** if QTc is 500ms or above An abnormal ECG should not delay the prescription of methadone **Refer** to primary care or ED for workup for abnormal ECG results in a timely manner based on the client's presentation
Tests for Health Promotion, to be Offered as Clinically Indicated These tests should not be a barrier to resuming prescriptions	

Hepatitis A, B, and C serology	• Review BC Centre for Disease Control (BCCDC) resources for interpretation of chronic and active infection
	• Registered nurses and RPNs who have completed the BCCDC's Immunization Competency Course can:
	  • Use Hep A and B serology to determine client immunity
	  • Recommend immunization where appropriate
	• Registered nurses and RPNs can call the BCCDC line for support with interpretation but may need to refer to another provider for management that requires treatment

HIV test	• Registered nurses and registered psychiatric nurses should complete the HIV Point of Care Testing Online Course prior to conducting point-of-care tests or ordering HIV serology, and be familiar with organizational pathways for referrals
Sexually transmitted infections	**Gonorrhea and chlamydia (GC/CT urine or swab)** • Registered nurses Sexually Transmitted Infections Certified: can diagnose and treat within the STI-certified practice DSTs • Those without certified practice Sexually Transmitted Infections: Refer to an STI-certified RN, an NP, or a physician for positive test results **Syphilis serology** • For interpretation, call the BCCDC line • **Refer** to another provider for diagnosis and management that requires treatment **Note**: If RN/RPNs order any of the tests above, they must follow up and ensure appropriate reporting of certain diseases (e.g., syphilis must be reported to CDC)

APPENDIX 3

BC's Drug Schedule Regulations

British Columbia's drug schedule regulations are a classification tool for drugs, substances, and chemicals. Drug schedules are classified in order of the potential for a person to develop a substance use disorder; Schedule I drugs are considered to have the highest risk of non-medical use.

Schedule	Examples
Schedule I	• Clonidine
Schedule IA (Triplicate/duplicate Prescription Program)	• Opioids (e.g., buprenorphine, methadone, morphine)
Schedule II	• Loperamide
Schedule III	• Acetaminophen and ibuprofen (in oral, fixed-dose combinations in package sizes containing 20,000mg or less of acetaminophen and 6,000mg or less of ibuprofen) • Dimenhydrinate

APPENDIX 4

Further guidance and Additional Resources

24/7 Addiction Medicine Clinician Support Line

To speak to an addiction medicine specialist, call 778-945-7619.

Provides telephone consultation from an addiction medicine specialist to physicians, nurse practitioners, registered nurses, registered psychiatric nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment. The 24/7 line is available to any frontline staff working in Indigenous communities in BC. Consultation can include support in screening, assessment, treatment, and management of substance use and substance use disorder(s).

- BC PharmaCare: Current PharmaCare plans and drug coverage
- BCCSU Opioids: A Survivor's Guide: A handbook about the different types of OAT
- Canadian Nurses Protective Society: A not-for-profit society that offers legal advice, risk-management services, legal assistance, and professional liability protection related to nursing practice
- Day Calculator: It may be helpful to use a day calculator to determine the duration when writing prescriptions
- Guidelines and Protocols Advisory Committee's (GPAC): OUD Induction Handout
- Guideline for the Clinical Management of Opioid Use Disorder: BC Provincial guideline for the management of opioid use disorder
- Treatment of Opioid Use Disorder for Youth Guideline Supplement: Focused on the management of OUD for youth (age 12–25)
- Provincial Opioid Addiction Treatment Support Program: Mandatory online training program offered by the BCCSU and UBC CPD for prescribing OAT in BC
- Clinics accepting new OAT clients: Contact information for OAT clinics across BC currently accepting new OAT clients
- Toward the Heart: Current listing of harm reduction services in BC that provide safer drug consumption supplies, drug poisoning prevention training, and take-home naloxone kits
- Lifeguard Digital Health: App that is activated by a person before they use opioids and alerts emergency medical dispatchers to a potential drug poisoning
- Up to Date: Clinical decision support tool and current drug–drug interactions

APPENDIX 5

Abbreviations

The following abbreviations are used throughout this DST:

ALT: alanine aminotransferase
Bup/nlx: buprenorphine/naloxone
CNS: central nervous system
CP-OUD: Certified Practice Opioid Use Disorder
CYP: cytochrome
CYP3A4: cytochrome P450 3A4
DST: decision support tool
ECG: electrocardiogram
eGFR: estimated glomerular filtration rate
GC/CT: Neisseria gonorrhoeae/chlamydia trachomatis
INR: international normalized ratio
MAOI: monoamine oxidase inhibitor
OAT: opioid agonist treatment
OUD: opioid use disorder
QTc: corrected QT
RN: registered nurse
RPN: registered psychiatric nurse
SNRI: serotonin-norepinephrine reuptake inhibitor
SSRI: selective serotonin reuptake inhibitor
STI: sexually transmitted infection
SROM: slow-release oral morphine
UDT: urine drug test
Z-drugs: non-benzodiazepine medications typically prescribed for insomnia (e.g., zopiclone, zolpidem, zaleplon)