BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
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COVID-19: INFORMATION FOR OPIOID AGONIST TREATMENT PRESCRIBERS AND PHARMACISTS

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On March 11, 2020, the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. The novel coronavirus has caused a global outbreak of respiratory infections since its discovery in December 2019. Although the scientific understanding of the effects of COVID-19 continues to grow, it is known that symptoms can range from mild (e.g., cough. fever) to severe (e.g., pneumonia, requiring hospitalization).

The situation regarding COVID-19 continues to evolve in BC, Canada, and other jurisdictions around the world. Federal and provincial health officials have urged individuals on chronic medications to acquire an adequate supply of prescription drugs. Ensuring uninterrupted access to essential medications, including opioid agonist treatment (OAT) medications for patients with opioid use disorder, is of critical importance to reduce the risk of harms and death that can be associated with medication destabilization.

This bulletin presents guidance and considerations for OAT prescribers and pharmacists in BC to ensure patients can access needed medications while reducing COVID-19 related risks, during this extraordinary period of dual public health emergencies. COVID-19 response planning should include plans for how to return to normal practices following the resolution of the COVID-19 emergency.

This bulletin contains the following information:

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1. PREPAREDNESS PLANNING FOR PATIENTS ON (ORAL AND INJECTABLE) OAT

Clinic and program administrators should review their space and patient flow, patient protocols, and cleaning procedures to determine if current procedures are sufficient to reduce risk of viral transmission.

Some clinics and programs may be able to safely continue operations and provide OAT to all patients, as per normal practices, during the COVID-19 pandemic.

Many patients prescribed OAT currently receive daily witnessed medications, but those who are immunocompromised and those who exhibit symptoms or who are in self-isolation may not be able to attend medical appointments or present to the pharmacy for their witnessed dose or to pick up take-home doses. To facilitate continued access to OAT medications, all health care providers should:

- Talk with all patients about COVID-19, including ways to reduce risk of infection and any specific concerns related to an individual's health (e.g., existing chronic health conditions, immunosuppression). See General COVID-19 Preparedness Practices, below
- Develop a contingency plan with patients, in the event they are unable to come in for appointments or access all of their medications through regular means, including OAT
- Develop contingency plans for potential staff shortages
- Consider alternative avenues to get essential medications to patients that both reduce the number of patient visits (e.g., extending prescription durations) and promote physical distancing (e.g., telemedicine). This may also include pharmacy delivery of OAT (see Guidance for Pharmacists, below), where services exist. If delivery is not an option, prescribers and pharmacists should work closely together to ensure patients can pick up medications with proper safety precautions in place
- Support patients who may continue to use alcohol and illicit drugs during this pandemic. Interim clinical guidance is available on the BCCSU's website to support prescribers to prevent clients from experiencing unsupported withdrawal while adhering to physical distancing and self-isolation measures

In order to support continuity of care and medication access, detailed information is provided below for prescribers and pharmacists.

2. GUIDANCE FOR OAT PRESCRIBERS

- Carefully document in the patient's medical record the rationale for any treatment plan augmentations or alterations due to COVID-19. Enter all prescriptions into PharmaNet
- Specific guidance for different types of OAT:

Buprenorphine/naloxone

Buprenorphine/naloxone: If possible, and with a discussion of the risks and benefits with the patient, consider transitioning to buprenorphine/naloxone—first-line treatment for opioid use disorder. Given the superior safety profile, patients can receive longer duration carries (a benefit if they are in self-isolation) and there is reduced risk of overdose and diversion

- Micro-induction may be considered for individuals transitioning from another OAT medication to buprenorphine/naloxone, to avoid the need for a washout period and moderate withdrawal to be reached prior to induction[1]
- Where clinically appropriate, prescribers should prescribe carry doses in blister packages, if available, by indicating this on the prescription for the pharmacy to arrange

Methadone

Any formulation of **methadone** (Methadose, Metadol-D, Sandoz Methadone [Sterinova], or compounded methadone): Where clinically appropriate, prescribers should consider temporarily allowing carry doses in adequately stable patients, including longer take-home intervals and fewer in-person appointments, supporting uninterrupted access to these essential medications

Sustained release oral morphine

Sustained release oral morphine (SROM; Kadian): prescribers should temporarily prescribe carry doses, whenever clinically appropriate (e.g., a stable patient with a secure place to store up to a week's supply of medication)

- For daily witnessed ingestion (DWI) doses (e.g., patient deemed too unstable or patient unable to safely store a week's supply of medications), consider not recommending 'sprinkling' (i.e., opening capsules and sprinkling medications) in the prescription. Indicate this clearly on the prescription and communicate with the pharmacy if necessary. This will reduce the amount of time patients spend in pharmacy and reduce medication handling and interactions with pharmacy staff
- Note: There is a potential Kadian shortage currently. More information available here

Injectable OAT

For patients on **injectable OAT** (hydromorphone and diacetylmorphine), see specific medication guidance below.

[1] *See Klaire, 2019 for a rapid micro-induction protocol and guidance from the BC Pharmacy Association for more information and a slower micro-dosing protocol (the Bernese method); consider consulting the RACE line if additional guidance necessary*

- Ensure prescription does not end on a weekend, statutory holiday, or other time in which prescriber would not be available. If prescription is DWI, ensure that carries are included for statutory holidays. The exact date(s) of carries must be specified on the prescription
- The duration of carry doses should be individualized
    - For patients with symptoms or in isolation, consider means by which patients can have medications safely delivered for daily witnessed doses, or increase carries to ensure adequate medication
    - Note that the duration of carry or delivery can be written as part-fill in the SIG for a longer prescription (e.g., 7-day weekly carry with first dose witnessed)
- When prescribing longer duration of carry doses, clinicians must weigh the benefits of larger dispenses with the risk of overdose, diversion, or risk to household members. In any case where carry doses are provided, counselling on safe storage of medication is critical. Also, ensure that patients have naloxone kits and training on their use
- Urine drug tests should only be used when clear clinical utility exists. A negative urine drug test is not required in order to prescribe take-home doses
- Wherever possible, provide support to patients via telemedicine (telehealth/virtual service billing codes). A reminder that billing codes for OAT may be eligible for telehealth visits and some may be billed when delegated to a nurse (see OUD billing codes for more information)
- During the pandemic, it is now acceptable for prescribers to fax prescriptions, or give verbal prescriptions for controlled drugs to pharmacists, and then deliver (by mail courier or other means) a hard copy of the original duplicate prescription at a later date. More information on the changes to date can be found on the College of Physicians and Surgeons of BC's website and the BC College of Nursing Professionals website

3. GUIDANCE FOR PHARMACISTS

- Consider whether there will be stable and predictable hours of operation and delivery options for those who receive OAT daily and communicate clearly to patients
- Where appropriate, consider pharmacist delivery of OAT medications to patients as outlined in the College of Pharmacists of BC's Professional Practice Policy-71 Delivery of Opioid Agonist Treatment
- Methadose, Metadol-D, and Sandoz Methadone (Sterinova) are all commercially available methadone 10mg/mL products that meet the Health Professions Act definition (section 25.91) of an interchangeable drug. For more information and key considerations when deciding on a formulation, please see the BCCSU Methadone Formulations Options Bulletin. Patient preference should be taken into account when considering a change.
- Further information for pharmacists is available on the CPBC website: https://bcpharmacists.org/covid19
- In the context of the pandemic, Health Canada has issued additional exemptions under the Controlled Drugs and Substances Act (CDSA) for prescriptions of controlled medications, including OAT, effective March 19, 2020. The exemptions:

    - Permit pharmacists to extend prescriptions
    - Permit pharmacists to transfer prescriptions to other pharmacists
    - Permit prescribers to issue verbal orders (i.e., over the phone) to extend or refill a prescription
    - Permit pharmacy employees to deliver prescriptions of controlled substances to patient's homes or other locations where they may be staying.
    - Guidance on operationalizing these exemptions is available on CPBC's website.

The BCCSU will make every effort to stay apprised of potential disruptions in the drug supply chain or other factors that may affect medication availability and will provide updates as they become available.

4. GUIDANCE FOR INJECTABLE OAT PROGRAMS

The options provided below are meant to support established health authority-operated injectable opioid agonist treatment (iOAT) programs. The guidance provided is aimed at programs that are unable to continue normal operations.

Clinics that provide iOAT should ensure that relevant public health and occupational health and safety protocols are in place, in the context of COVID-19.

Clinics may consider the following medication transitions aimed at reducing the number of patient visits per day and to support patients in isolation:

OPTION 1: Transition one or more injection doses to oral OAT alone

Medication selection

- If patient has an existing oral OAT co-prescription, consider increasing dosage to compensate for the reduction in iOAT doses
- If replacing some but not all iOAT doses with oral OAT, prescribe slow-release oral morphine (SROM) or methadone.
    - Use the conversion table to determine the equivalent dosage for SROM and methadone
    - SROM may be preferable due to its better safety profile and significantly lower variability in required dosage
    - Methadone formulations must be titrated slowly (5–10mg every 5+ days) due to the variability in absorption rates, slow bioaccumulation, and long half-life.
        - Due to incomplete cross-tolerance between types of opioids, frequent follow-up and monitoring is recommended to ensure correct dosing for each patient
- If replacing all doses with oral OAT, based on patient preference and prescriber discretion, transition to buprenorphine/naloxone may be considered
    - Buprenorphine/naloxone is not an appropriate co-prescription; due to its high affinity for the opioid receptor, it preferentially binds to the receptor and displaces other opioids if they are present, which can cause precipitated withdrawal
    - If transitioning fully to buprenorphine/naloxone, induction is possible in 1–3 days, but can take longer
- See above guidance and refer to the CRISM National iOAT Clinical Guideline for more information on transitions from iOAT to oral OAT

Features of this option

- This may be a useful approach for clinics with limited capacity, physical space, and resources
- Benefits: Oral OAT medications have a significant body of evidence showing safety and efficacy. They are relatively safe to be provided as take-home doses, and witnessing of doses is on a case-by-case basis. If a patient is treated solely with oral OAT, longer prescriptions and take-home doses would more easily facilitate patients to remain in isolation if needed.
- Disadvantages: Transitioning to oral OAT can result in de-stabilization and a return to illicit opioid use to avoid withdrawal symptoms and cravings.

OPTION 2: Provide take-home oral hydromorphone, to replace one or more iOAT doses

Prescribing considerations

- Patients on diacetylmorphine would need to be converted to hydromorphone
  - Use the conversion table to determine the equivalent dosage
  - Ensure that pharmacy has adequate supply
- Oral hydromorphone is available in 8mg tablets. Using a simple dosage conversion from IV to oral may result in a in a dose that is inappropriately high. Thus, use clinical judgment to determine a starting dose of oral HDM (e.g., 1-3 tablets q1h as needed up to 14 tablets) and adjust dose as needed
- Daily dispensing is preferred
  - If continuing with one injected dose in clinic, oral hydromorphone can be provided for the remaining hours of the day
  - Pre-dose assessment in clinic should include asking the patient when the previous day's take-home doses were taken
  - Instruct patient to wait at least 3 hours after the injected dose in clinic before starting the take-home doses
  - Use clinical discretion to determine whether witnessing is required
  - Arrange for regular check-ins and monitoring, including remotely where available
  - Given that some patients may inject this medication rather than using the intended oral route, prescribers should advise patients on safer injection practices and safe disposal of syringes, as well as provide necessary supplies, if available
  - Recommended only if the patient is on a stable dose of iOAT, has had no recent post-dose complications, and has adequate housing
- For patients in isolation due to COVID-19, daily delivery and witnessing may be possible by a pharmacist

Features of this option

- Appropriate if Option 1 is deemed to be less optimal for meeting client's treatment needs, based on clinical judgment, and Option 3 is not available.
- Benefits: When replacing one dose of iOAT, oral HDM may be less likely to de-stabilize a patient than oral OAT alone. Injectable opioid agonist treatment patients have trialed oral OAT alone and continued to experience cravings and symptoms of withdrawal.
- Disadvantages:Oral HDM is not an evidence-based treatment for opioid use disorder and thus, clinicians must rely on their professional judgment, weigh the risks and benefits, and make a care plan that is in the best interest of the patient. There is a risk of destabilization, over-sedation, or undertreatment due to the challenge of converting dosage from IV to oral

OPTION 3: Provide pre-filled syringe(s) of hydromorphone as a take-home dose, once per day

This option should be considered on a case-by-case basis by the prescriber and the iOAT care team for one or more of the doses prescribed on any given day. It should only be considered in situations where self-isolation has been recommended by a health care provider, when all options to support the patient to attend the iOAT clinic have been explored, and a transition to oral OAT is unlikely to be or has been unsuccessful.

Prescribing considerations

- Patient should be on a stable dose of iOAT, have no active concurrent substance use disorder, and have had no recent post-dose complications.
- Doses must be dispensed on a daily basis, there should be a reasonable plan for dose transportation, and patient education regarding home administration provided.
- Consideration should be given to alternative procedures for pre and post injection assessments, supervision of injection and appropriate spacing of doses.

Features of this option

- Benefits: Maintaining injectable hydromorphone is likely to support clinical stability compared to switching to an oral medication, as seen in the SALOME trial.
- Disadvantages: There are safety risks both during transport home and for the patient, and potential for diversion with take-home doses.

5. GENERAL COVID-19 PREPAREDNESS PRACTICES

- Clinicians should follow hand hygiene, respiratory etiquette, and social distancing measures and advise patients to do the same. Have hand sanitizer available and consider face masks for those who present with respiratory symptoms. More information can be found on the Government of Canada website.
- Clinicians should ensure patients have an adequate supply of other required medications (e.g., for HIV, hepatitis C, other chronic conditions) that may be necessary during a period of quarantine, providing extra refills as appropriate.
- Clinicians should provide information about COVID-19 to patients, including about social distancing measures when visiting the pharmacy or clinic, and refer patients to the BC Centre for Disease Control for more information.
- The BC Centre for Disease Control has created guidance for responding to an overdose in the context of the COVID-19 pandemic, including when rescue breaths and ventilation are required.
- The Harm Reduction Coalition has published a fact sheet on COVID-19 operational practices for harm reduction providers, which provides additional relevant guidance.

6. DEVELOPMENT OF THIS BULLETIN

This bulletin was developed following consultation with oral and injectable OAT providers in Canada and international jurisdictions. The suggestions and considerations included in this bulletin were synthesized from those providers and were revised through multiple rounds of review by a group of addiction medicine experts in BC. To collate guidance for iOAT specifically, BCCSU staff consulted with health professionals from Germany, the Netherlands, and Canada (including Alberta and BC).

In order to provide brief and practical guidance in the context of the COVID-19 pandemic, this document does not include a review of the scientific evidence and intends for prescribers to rely on their clinical judgment when utilizing this guidance. A comprehensive evidence review on the efficacy of oral and injectable OAT can be found in the provincial Guideline for the Clinical Management of Opioid Use Disorder and the National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline.

7. ADDITIONAL RESOURCES

811 call centre focused on COVID-19 queries
1-888-COVID19 (268-4319)

British Columbia Centre for Disease Control
- For health care providers (link)
- For the public (link)
- For people who use drugs and registered harm reduction and naloxone sites (link)

Rapid Access to Consultative Expertise (RACE) for Addictions
- Consultation and support for prescribers
- Available M–F 8am–5pm at http://www.raceconnect.ca/ ; 604-696-2131; Toll free: 1-877-696-2131