BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

FREQUENTLY ASKED QUESTIONS

PANDEMIC PRESCRIBING IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

June 10, 2020

In March 2020, the Province of BC and the BC Centre on Substance Use released the interim clinical guidance document *Risk Mitigation in the Context of Dual Public Health Emergencies* to respond to the dual public health emergencies of the COVID-19 pandemic and the overdose crisis. In the weeks that followed, a number of webinars, seminars, and other guidance dissemination activities took place in an effort to support health care providers to implement this guidance. This document aims to collate and address the frequently asked questions the BCCSU has received about the interim guidance.

CONTENTS

ABOUT THE INTERIM GUIDANCE

1. **Does the interim clinical guidance replace previous guidelines for treating substance use disorders?**
   The protocols outlined for pandemic prescribing are not intended for the treatment of substance use disorders, but are measures meant to reduce harms for people who use drugs (PWUD) in the context of COVID-19. These protocols are meant to be used in conjunction with existing clinical guidelines and guidance from public health officials about reducing the spread of the novel coronavirus SARS-CoV-2, which causes COVID-19.

2. **What will happen to patients who receive pandemic prescribing after the pandemic ends?**
   The interim clinical guidance is a temporary measure meant to reduce the risks of two public health emergencies. Much is still unknown about the coming months and the COVID-19 pandemic; however, public health officials have indicated that the health system, similar to all facets of society, will need to establish a "new normal." This will likely mean ongoing reduced physical contact and a gradual easing of restrictions. It is difficult to predict how this guidance will evolve in this ever-changing clinical landscape.

BC Centre on Substance Use
400-1045 Howe St
Vancouver BC V6Z 2A9
www.bccsu.ca

CRISM | BRITISH COLUMBIA · PROVIDENCE HEALTH CARE Research Institute · Providence HEALTH CARE · UBC · St Paul's FOUNDATION

In cases where prescribing according to the risk mitigation guidance has shown clear clinical benefit (i.e., reduced use of illicit drugs, supported by negative urine tests where clinically appropriate), continued prescribing after the pandemic may be clinically appropriate, in the context of the ongoing overdose crisis. Prescribers should have frank conversations with their patients about what care options are available to them to plan for continuity of care. Post COVID-19—and at any point during the pandemic—patients should be supported in reducing, discontinuing, or tapering their use of pandemic-prescribed medications (and transitioning to evidence-based pharmacotherapies for patients with diagnosed substance use disorders, as clinically appropriate and with consideration for their own personal goals).

3. **Will increasing carries of opioids put our patients at risk, such as by increasing overdoses?**
Prescribing controlled substances does carry risks that vary depending on the substance(s) and dosages that are prescribed. Prescribers should communicate with their patients about any risks associated with their prescribed medications to support the patient in making informed decisions about their substance use.

   However, in comparison to illicit supplies of opioids, prescription medications have known and consistent composition and potency. For people who actively use substances and are at risk of withdrawal, overdose, craving, or other harms from drug use, receiving prescribed medications may be an option to reduce their risk of adverse effects by avoiding a toxic drug supply. Increasing carries of prescribed medications for PWUD who are at risk of contracting SARS-CoV-2 will also enable patients to reduce exposure by minimizing trips to the pharmacy and decreasing contact with other individuals to purchase illicit substances. Prescribers should consider carry doses on a case-by-case basis and weigh the risks and benefits. To reduce the risk of diversion when prescribing carry doses, prescribers should ensure that individuals are able to store medications in personal safes or medicine lock boxes in patient-specific lockers, and collaboratively develop a plan for safe storage. This safe storage plan should include determining whether there are are children in the household and ensuring they are not able to access the medication(s).

4. **What is the evidence regarding prescribing stimulants as part of the interim clinical guidance?**
Studies to date on stimulant replacement have shown no impact on treatment retention or abstinence, but have demonstrated a generally good safety profile.[1,2] There is a lack of scientific evidence regarding prescribed stimulants as a harm reduction approach. The protocols in the interim clinical guidance are meant to replace illicit stimulants with prescribed stimulants to support physical distancing while reducing the risk of withdrawal and harms from accessing a limited and toxic drug supply. This guidance is not meant to be interpreted as an evidence-based treatment approach for stimulant use disorder but a measure to reduce exposure to—and spread of—SARS-CoV-2 and other harms related to the toxic illicit drug supply, when clinically appropriate.

---

[1] Bhatt M, Zielinski L, Baker-Beal L, et al. Efficacy and safety of psychostimulants for amphetamine and methamphetamine use disorders: A systematic review and meta-analysis. Syst Rev. 2016; 5(1):189. 10.1186/s13643-016-0370-x

[2] Castells X, Cunill R, Pérez-Mañá C, Vidal X, Capellà D. Psychostimulant drugs for cocaine dependence. Cochrane Database of Systematic Reviews. 2016; (9). 10.1002/14651858.CD007380.pub4

Prescribers should be aware of the risks and contraindications of prescribed stimulants and consider these implications when exploring this as an option for their patients.

5. **Why does this approach focus on stimulant maintenance rather than tapers when clinically appropriate?**
   The interim clinical guidance is meant to provide support for clinicians treating patients whose risk cannot be lowered with standard evidence-based approaches. If the patient has stated that they would like to reduce their stimulant use, and it is determined to be clinically appropriate, a taper regimen can be offered. However, for patients who are not ready to begin a taper, pandemic prescribing of stimulants can help patients practice physical distancing and self-isolation without experiencing withdrawal or having to access the toxic illicit drug supply.

6. **How can we mitigate diversion when it comes to pandemic prescribing?**
   To minimize the risk of diversion, patients receiving pandemic prescribing should, when possible, receive their medications daily. In instances where the patient is not able to pick up their dose every day (e.g., those self-isolating due to suspected COVID-19), patients can be supported by delivery facilitated through their housing provider, pharmacy (depending on delivery capacity), or a clinical outreach team. Carries can be considered in cases where the patient may have difficulty coming to the pharmacy every day, such as in rural or remote communities. For patients concurrently on opioid agonist treatment (OAT), the appropriateness of take-home dosing should be assessed on a case-by-case basis. Prescribers should discuss each patient's living situation and develop a plan together. Considerations include housing situation (e.g., living in their own apartment vs. staying in a shelter or supported housing), the presence of children, and safe storage options (e.g., a medication lock box, personal safe, or locker).

7. **Did the interim clinical guidance have authors or reviewers who provided a rural and remote lens?**
   The initial protocol for the interim clinical guidance was conceived by a group of addiction clinicians in the Vancouver Coastal Health (VCH) region. Their approach towards harm reduction was adapted by the province to develop the interim clinical guidance, involving authors and reviewers with a wide range of backgrounds from regional health authorities and the First Nations Health Authority (FNHA). The interim clinical guidance was later updated to include a section on considerations for remote and rural areas, and there is ongoing work to include a rural-focused case study in revised versions of the interim clinical guidance.

8. **How does the interim clinical guidance relate to the Controlled Drugs and Substances Act exemptions issued by Health Canada?**
   The interim clinical guidance is separate from temporary exemptions issued by Health Canada. The temporary exemptions issued by Health Canada in the context of the pandemic under the Controlled Drugs and Substances Act (CDSA) for prescriptions of controlled medications, including OAT, effective March 19th, 2020:

- Permit pharmacists to extend prescriptions[3]
- 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[4]

These exemptions support a number of practices aimed at minimizing clinic and pharmacy contact and supporting patients to physically distance and self-isolate in the context of COVID-19. Subsequently, the exemptions support the implementation of the interim clinical guidance by reducing barriers to accessing OAT and the medications in the guidance, thus improving continuity of care.

9. **What recommendations and advice do you have for others who want to adopt the interim clinical guidance nationally or internationally?**
The interim clinical guidance document is based on evidence—where available—and clinical expertise, and has been developed to meet the challenges of the rapidly changing context of dual public health emergencies in British Columbia. Wherever possible, evidence-based treatments should be offered to those with a diagnosed substance use disorder. However, the significant risks faced by PWUD during the COVID-19 pandemic necessitates the use of clinical judgement and novel approaches to reduce risks and harms. With the understanding that this interim clinical guidance was developed rapidly at the request of the Province due to urgent need, it can be used as a template for developing additional, region-specific guidance, in collaboration with clinical addiction experts, health systems partners, policy makers, researchers, and community stakeholders.

ELIGIBILITY

10. **What criteria should be used to determine eligibility for prescribing these suggested substitution medications?**
As with any health issue, treatment decisions should be made collaboratively by the patient and their prescriber (i.e., physician or nurse practitioner). Decisions to prescribe must be made considering a number of factors, and not everyone may be eligible for a particular medication or treatment option.

Eligible clients must meet the following criteria:

- Individuals who are at risk of COVID-19 infection, those confirmed COVID-19 positive, or those with a suspected case (e.g., symptomatic and self-isolating)

[3] In BC, this is usually in the form of emergency supply for continuity of care per PPP-31. Guidance on operationalizing these exemptions for pharmacy is specific to each province. In BC, guidance is available on the College of Pharmacists of British Columbia (CPBC)'s website.

[4] Refer to the CPBC website for more information and specifics on supporting delivery of controlled drugs.

- Individuals who have a history of ongoing active substance use (opioids, stimulants, alcohol, benzodiazepines, or tobacco)
- Individuals who are deemed at high risk of withdrawal, overdose, craving, or other harms related to drug use

Patients who are currently on OAT should be assessed based on their OAT medication and dose as well as any illicit opioid use and the presence of any withdrawal symptoms or cravings. Options to reduce risks associated with accessing the illicit drug supply include increasing OAT dose, providing carries and/or delivery of OAT, or potentially supplementing OAT with pandemic prescribing. Patients who are engaged in other substance use care (i.e., outpatient treatment, other pharmacotherapies, recovery and other psychosocial supports) should be assessed for eligibility and appropriateness of pandemic prescribing.

11. **How is "at risk of COVID-19" defined in this document?**
At present, everyone is at risk of COVID-19 infection. Although the sociodemographic characteristics of PWUD in BC varies greatly, in some cases PWUD may be especially at risk—for example, patients who are not able to practice appropriate self-isolation due to the interaction required to generate income or access the illicit drug supply. People who use drugs may also experience co-morbidities that can increase the risk of serious illness from COVID-19. For individuals who are actively using substances and are at risk of withdrawal, overdose, craving, or other harms from drug or alcohol use, receiving prescribed medications may be an option to reduce their risk.

12. **Are chronic pain patients who are in the midst of recommended opioid tapering, or who have not yet begun, eligible for pandemic prescribing?**
The decision to prescribe pharmaceutical-grade opioids should be individualized and based on a variety of factors, including current use of illicit opioids, health and substance use history, and patient goals. Patients who have been prescribed opioids long-term for chronic pain can continue their current treatment plan, including tapering where appropriate, and would only be eligible for pandemic prescribing if the prescriber felt that it may be clinically appropriate for patients who access the illicit drug supply.

13. **Is pandemic prescribing something we should be considering for any and all patients with active opioid use disorder (OUD) alongside OAT at this time or is OAT still "first line"?**
Opioid agonist treatment is still considered first line treatment for patients with active OUD. If patients are not achieving success on OAT, healthcare providers should follow the provincial Guideline for the Clinical Management of Opioid Use Disorder, which offers guidance to optimize OAT including considering different options along continuum of care.

If a patient is not ready or willing to begin OAT, pandemic prescribing may be an option. It may also be an option for patients who are on a therapeutic dose of OAT but continue to use illicit opioids to manage cravings and withdrawal symptoms.

TELEHEALTH

14. Can pandemic prescribing be done via telehealth?

For new patients, wherever possible, it is preferable to conduct the medical assessment and prescribe controlled substances in person. The College of Physicians and Surgeons of BC's (CPSBC) practice standard for telehealth states that physicians "*must only prescribe opioid medications to a patient if they have:*

- *A longitudinal treating relationship with the patient and have examined the patient themselves*
  OR
- *Are in direct communication with another physician or nurse practitioner who does have a longitudinal relationship, has examined the patient and agrees that opioids are indicated*
  OR
- *The patient is receiving palliative end-of-life care, is established on opioid analgesics and is at risk of running out in extraordinary circumstances where the usual prescriber is temporarily unavailable*"

However, it is recognized that there may be circumstances in which seeing a patient in person is not possible (e.g., rural and remote settings, a patient who is in self-isolation). In these cases, prescribers should use clinical judgement and document their rationale for seeing a patient remotely. Prescribers should remain up-to-date on public health orders and any updates from their regulatory college. College of Physician and Surgeon COVID-19 updates are available here; College of Nursing Professionals of BC COVID-19 updates are available here.

Refer to the following resources for guidance on virtual care:

- Doctors of BC: New Guides for Physicians on Using Virtual Care
- College of Physicians and Surgeons of British Columbia: Prescribing Medications During the COVID-19 Pandemic
- CPSBC Practice Standard: Telemedicine
- BC College of Nursing Professionals: Prescribing Drugs: Standards
  a. The BC College of Nursing Professionals has specific standards for nurse practitioners prescribing narcotics via telehealth on their website—see nurse practitioner scope of practice (principle 13).
- Rapid access addiction clinics (RAACs) may be able to provide telehealth support for patient assessment.
  a. Victoria: 250-381-3222
  b. Vancouver: 604-806-8867
  c. Surrey: 604-587-3755
- Vancouver Coastal Health: Prescriber Guidelines for Risk Mitigation in the Context of Dual Public Health Emergencies

15. **What if telehealth is not a feasible method to reach my patients (e.g., patients who lack access to a phone)? Is it appropriate to extend prescriptions for pandemic prescribing to ensure patients do not run out?**
    Prescribers can check PharmaNet for missed doses or contact the pharmacist to discuss the patient's status (e.g., how they are doing, if the dose is working for them, and any concerns such as over-sedation). In the event prescribers are working remotely and cannot access PharmaNet, alternative arrangements may be needed to access this information. Prescribers are encouraged to create a plan for accessing PharmaNet and connecting with pharmacist colleagues. Pharmacists can offer an emergency supply of prescription drugs (including controlled substances) for continuity of care within their scope, under Professional Practice Policy-31, if appropriate.

16. **What billing codes are relevant for telehealth and pandemic prescribing?**
    Non-procedural interventions provided by video or telephone where there is no telehealth fee should be billed under the equivalent face-to-face fee with a claim note record stating the service was provided via telehealth. Some relevant examples include:
    - Assessment for induction of OAT: 13013
    - Management of OAT induction for OAT: 13014
    - Methadone or buprenorphine/naloxone treatment only: 00039
        - Note: The required once-every-90 day follow ups for this billing code can be met by providing a telehealth visit (see billing codes below)

    For visits that normally would be billed as 0100 or 0120 series when provided in person, use the billing codes for telehealth visits instead:
    - Telehealth GP in-office visit: 13037
    - Telehealth GP in-office individual counselling: 13038

    Pandemic prescribing should be billed as telehealth or in-office visits. If OAT is being prescribed or managed concurrently, OAT billing codes can also be used. If multiple visits on the same day are required, multiple codes can be billed, with a claim note stating the reason for the additional visit.

    COVID-19 billing codes are not applicable for pandemic prescribing, as these are meant to be used for in-office visits by patients with suspected or active COVID-19 symptoms.

PRESCRIBING

17. **Can a medical office assistant (MOA) contact pharmacies by phone on behalf of the prescriber to provide verbal orders for controlled drugs or Schedule 1A drugs?**
    Verbal orders for controlled substances (e.g., opioids, benzodiazepines) must be given directly from a prescriber to a pharmacist—MOAs cannot issue these orders. For Schedule 1A medications, following a phone order, an original Controlled Prescription Program (CPP) form must be sent to the pharmacy as soon as it is reasonably possible to do so.

Refer to the CPBC website and the *Pharmacy Operations and Drug Scheduling Act* Bylaws for more information.

18. **If I give a verbal order for a controlled medication to the pharmacist, do I still need to send the hard copy of the CPP form?**
The hard copy of the CPP form must always be sent to the pharmacy as soon as it is reasonably possible to do so.

Refer to the CPBC website for more information.

19. **What is legally required in order to fax a prescription to a pharmacy?**
In a public health emergency declared by the provincial health officer, a community pharmacy may receive a prescription for a drug referred to on the CPP Drug list by fax. The pharmacy must receive a completed copy of the CPP form transmitted by fax prior to dispensing the drug, and the original CPP form must be sent to the pharmacy as soon as reasonably possible (e.g., by mail, courier). Prescriptions not requiring a CPP form do not need to have the original provided to the pharmacy.

See the Health Professions Act (HPA) Bylaws Schedule F, Part 1 (Community Pharmacy Standards of Practice), available here, for information on what must be included when faxing a prescription to a pharmacy.

Refer to the CPBC website for more information and specifics.

20. **Is there rough reference guidance for terms, values, and amounts of illicit drugs (e.g., points, papers) to help understand what substance and how much my patient is currently using?**
An important component of the patient assessment is determining current substance use (including type of substance and amount, route of administration, and frequency of use). When describing current use, patients may refer to substance use with non-medical terms, measurements, and monetary values. The table below provides information about common names, terms, and amounts of illicit drugs.

While patient information about current use and patterns of use may help to guide prescribing, including estimating a target dose, the composition and potency of illicit substances is often unknown and can vary widely. For this reason, patients should be started at a lower dose than what they regularly purchase and titrated up to clinical effect. The guide provided below is not exhaustive—and may vary by region—but may be helpful when discussing current substance use with your patient.

	Opioids (aka “down”, “fent”)	**Stimulants** (aka “rock”, “powder” [cocaine]); “meth”, “crystal”, “jib”, “shards” [methamphetamines])	**Benzodiazepines** (aka “bennies”, “benzos”, Valium, Xanax)

Street Values	1 paper = $10 1 point = $20 Quarter gram = $35–40 Half gram = $60-80 1 gram = $100-120	1 paper = $10 1 rock = $10 Half gram = $40 1 gram = $80	1 Valium yellow = $0.50 1 Valium blue = $1 1 Xanax = $5–10
Common amounts	1 point = 0.1g or 100mg 1 paper = half a point or 50mg	1 point = 0.1g or 100mg 1 paper = half a point or 50mg 1 rock (crack) = 1–1.5 points	"Valium" = 10mg (blue) "Valium" 5mg (yellow) "Xanax"= 2mg

21. **Can nurse practitioners offer pandemic prescribing, utilizing the interim clinical guidance?**
Prescribing controlled substances, including pandemic prescribing within the interim clinical guidance, is within the scope of practice for nurse practitioners. See the BC College of Nursing Professionals' Standards for more information on nurse practitioner prescribing.

22. **How can prescribers be supported with increased call and request volumes?**
Prescribers should support existing patients in meeting their health needs. At present, there are a limited number of prescribers engaged in pandemic prescribing and patients may be looking to connect to care if they don't have a primary care provider. For prescribers facing increased call and request volumes, several resources are available:
    - Rapid access addiction clinics (RAACs) may be able to provide telehealth support for patient assessment.
        - Victoria: 250-381-3222
        - Vancouver: 604-806-8867
        - Surrey: 604-587-3755
    - OAT Clinics Accepting New Patients: This list may be consulted to refer patients who are at risk of withdrawal and for whom OAT is clinically appropriate. Prescribers should check with their patients to determine if they have appropriate coverage for any applicable private clinic fees (e.g., First Nations Health Authority clients are able to get private clinic fees reimbursed) or other available funds.
    - The Northern Health COVID-19 Online Clinic and Information Line has been expanded to include a virtual substance use clinic. Patients can call the online clinic toll-free at 1-844-645-7811 to be screened and connected to local substance use services, where available, or with a virtual substance use care provider.

23. **Are there any suggested considerations for pandemic prescribing in rural and remote contexts?**
Rural and remote communities face unique barriers to both accessing and providing substance use care, including limited capacity of prescribers and pharmacists, limited outreach resources, and difficulties monitoring patients who may live some distance from the nearest healthcare services. Prescribers in these communities may need to give consideration to increasing the length of carries and arranging alternative means of follow up appointments (e.g., telehealth visits). Clinical judgement is required when weighing the overall harms of withholding this intervention versus the benefits of providing it.

Where available, telehealth can support family physicians and addictions specialists in consulting with patients from a distance. Prescribers can also consider consulting the RACEline for addiction medicine support (Monday–Friday 8am–5pm; Vancouver area: 604-696-2131; toll-free: 1-877-696-2131).

24. **What if a patient requests controlled substances through pandemic prescribing but does not meet the eligibility criteria, as stated in the interim clinical guidance?**
Currently, everyone in BC is at risk of COVID-19 infection. For people who actively use substances and are at risk of withdrawal, overdose, craving, or other harms from drug or alcohol use, receiving prescribed medications may be an option. As with any medical decision—where possible—a plan should be made in collaboration with the patient and prescriber and take into consideration the individual's goals, health status, risks, and potential benefits.

25. **What if a patient was stable on OAT and now wants to come off OAT in order to receive controlled substances under pandemic prescribing?**
Patients who are stable and experiencing successful treatment outcomes on OAT should be encouraged to continue their OAT. If patients come forward with questions about pandemic prescribing, this may be a good opportunity to discuss any challenges related to the patient's current treatment plan, and review the patient's current health goals including any goals related to opioid use (e.g., reducing their use of opioids).

    If patients are on OAT and still accessing the illicit market, pandemic prescribing can be offered in addition to their OAT without destabilizing their treatment. Healthcare providers should work with their patients to develop a treatment plan that realistically reflects their current use of illicit opioids while also supporting their health goals with OAT.

26. **If a patient is prescribed additional opioids per the interim clinical guidance while starting OAT (i.e., during the dose titration phase, to avoid illicit opioid use), would there be a point in time where we should be tapering the hydromorphone or M-Eslon, or would this depend on the individual's use?**
Tapering off pandemic prescribed medications should be evaluated on a case-by-case basis, considering the medications each patient is receiving and their social context. Where clinically appropriate, patients who have experienced benefits from pandemic prescribing of hydromorphone or M-Eslon to avoid illicit opioid use while stabilizing on OAT could be tapered off of the pandemic prescribing to determine if OAT alone meets their needs. Patients who have experienced benefit from pandemic prescribing and who continue to experience cravings and/or withdrawal symptoms on OAT may benefit from continued pandemic prescribing. The rationale, risks, and benefits should be carefully weighed and discussed and appropriately documented in the patient's medical record. As with any medical decision—where possible—a plan should be made in collaboration with the

patient and prescriber and take into consideration the individual's goals, health status, risks, and potential benefits.

27. **How often should I follow up with patients?**
    It may be challenging to follow up with patients during the pandemic, especially for those who may not be stably housed or have reliable access to phones, computers, or other community supports. In practice, weekly follow-ups may be reasonable for most patients. Depending on availability, it may also be possible to coordinate with clinical outreach teams to contact patients to organize or remind them about follow up appointments. See the Telehealth section in this FAQ for further guidance on following up with difficult to reach patients.

28. **For patients who are normally on Metadol-D and have to self-isolate, can I prescribe Metadol tablets?**
    The College of Pharmacists of BC Professional Practice Policy-66 states that "methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral formulation." The Policy Guide for PPP-66 similarly states that methadone must be dispensed as the commercially available 10mg/ml oral formulation, but allows for dispensation of methadone in tablet form for air travel (Principle 3.5.1). However, there may be exceptional circumstances during the COVID-19 pandemic in which Metadol tablets are clinically indicated, based on clinician assessment. This may include individuals who are self-isolating or avoiding potential exposure to COVID-19 who usually receive Metadol-D, and for whom concerns exist about the ability to safely store Metadol-D (for example, individuals without access to a refrigerator but who can access a personal safe or locker). Take-home doses must be dispensed according to Principle 4.1.6.

    It should be noted that Metadol tablets are not covered by regular PharmaCare benefits in BC but may be covered by private insurance or out-of-pocket for some patients. Prescribers should ensure that patients have a means to pay for medications that are not covered as regular benefits before prescribing them. You can check which medications are covered here.

29. **Is there a difference between generic hydromorphone tablets and brand name Dilaudid?**
    Generic hydromorphone tablets such as Apo-hydromorphone (manufactured by Apotex Corporation) and PMS-hydromorphone (manufactured by Pharmascience Inc.) are interchangeable with brand name Dilaudid tablets (manufactured by Purdue Pharma). Patients can ask their pharmacy about what is available or whether the pharmacy is able to bring a certain manufacturer's version in, as they may prefer one over the other—for example, patients who prefer the injection route have reported that some generic hydromorphone tablets seem visibly different (round pills instead of heart shaped) and leave significantly more residue if crushed, cooked, and drawn up for injection.

    Prescribers may indicate the patient's brand preference on the prescription or instruct the patient to ask for their preferred brand at the pharmacy. Although prescribers may also choose to write "Do Not Substitute" on the prescription if they do not wish the pharmacist to change the brand of hydromorphone tablet, this can cause delays (e.g., there may be shortages of the requested brand,

or the patient may wish to switch brands but requires confirmation from the prescriber), as this restricts the pharmacist to dispensing only the brand on the prescription.

30. **Is there a dosage equivalent from street stimulants to methylphenidate (Ritalin)?**
Equivalent doses for street stimulants are difficult to determine as many illicit stimulants have an unknown composition and potency. If methylphenidate is being prescribed during the pandemic as a replacement for illicit stimulants, prescribers should start their patients on a low dose and titrate up based on their clinical response. Patients with concurrent mental health disorders should be warned of the potential worsening of symptoms with prescribed stimulant medications and advised to stop or reduce their dose and/or present for medical help early should this occur.

31. **Does the interim clinical guidance provide guidance on interventions for individuals who are dependent on GHB (gamma-hydroxybutyrate) or other substances? If not, how should I treat these patients?**
The interim clinical guidance provides guidance on care planning and pandemic prescribing for individuals who use opioids, stimulants, benzodiazepines, alcohol, and tobacco. Prescribers needing support to provide appropriate care for patients who use other substances should consult the RACEline (Monday–Friday 8am–5pm; Vancouver area: 604-696-2131; toll-free: 1-877-696-2131).

32. **Are there harms associated with IM or IV injection of tablet or capsule formulations of controlled drugs?**
Any frequently administered injectable treatment is associated with higher risks of cutaneous and infectious complications compared to its equivalent oral formulation. Ongoing injection substance use, whether prescribed or illicit, poses a heightened risk of infectious complications. There are also specific harms associated with injecting oral formulations, which include local and systemic infection, skin and soft tissue injury, and pulmonary, cardiac, and vascular conditions. However, the known composition of prescribed medications compared to illicit drugs paired with patient education on safer injection practices and telehealth follow up may help reduce these risks. The goal of providing these pandemic prescribing options is to reduce the risk compared to the patient's baseline substance use. Currently, there is work underway in collaboration with the BC Centre on Disease Control (BCCDC) to provide guidance on reducing harms associated with injection of tablet formulations. Prescribers should take an individualized approach to assessing the risks and benefits for this kind of prescribing in the context dual public health emergencies.

ETHICAL AND REGULATORY CONSIDERATIONS

33. **What are my professional obligations as a clinician if I do not feel comfortable offering pandemic prescribing at my clinic?**
Prescribers must use their best clinical judgement, and practice within their scope and expertise. In the context of pandemic prescribing, this may require prescribers to make decisions in which they must balance their level of comfort with offering pandemic prescribing against the importance of ensuring patients have access to appropriate medical interventions. As the interim clinical guidance

relies on clinical expertise and a rapidly changing knowledge base, prescribers can practice professional autonomy in making decisions based on the current information available to them from clinical guidance, public health officials, and their evaluation of the patient.

Under the ethical principle of fairness, prescribers must ensure that access to medical treatment and care is provided consistently across populations and among individuals, regardless of personal characteristics (e.g., race, age, disability, ethnicity, ability to pay, socioeconomic status, pre-existing health conditions, perceived obstacles to treatment, past use of resources). Prescribers can refer to the COVID-19 Ethical Decision-Making Framework (EDFW) Interim Guidance released by the BC Ministry of Health and the BC Centre for Disease Control for additional guidance on ethical principles to follow in the context of the pandemic.

Prescribers who choose not to offer pandemic prescribing must:

a) Do so in a manner that respects patient dignity and be truthful and honest to individuals affected (see the COVID-19 EDFW); and
b) Ensure the patient is connected to an available and accessible prescriber in a timely manner to prevent exposing the patient to adverse clinical outcomes that could result from delay in accessing care.

34. What is my obligation to deliver medications if I feel that delivery puts me at significant risk of harm (e.g., contracting COVID-19, being targeted for theft)?

Healthcare providers have a duty to provide care, even if it involves potential exposure to risk of harm. If there is a potential risk to staff, precautionary measures to protect staff safety must be taken.

Examples of precautions for medication delivery include:

- Regularly reviewing and updating the delivery plan
- Having two staff members visit certain buildings where increased safety is necessary
- Ensuring that there is adequate personal protective equipment (PPE)
- Ensuring that medications are delivered in a non-descript bag or packaging
- Having staff performing the delivery avoid wearing clothing or badges that identify them as personnel who might have medications
- Where possible, having community housing buildings partner with a regular pharmacy provider who can access the building with a key or through a safe entrance (e.g., a staff entrance or secondary door)
- Following Health Canada's section 56 exemption to the *Controlled Drugs and Substances Act* delivery requirements, where applicable (these can be found here, under the heading "Additional Requirements from Health Canada")

When efforts to put precautionary measures in place for medication delivery have been exhausted and staff still face a certain and significant risk of harm (e.g., there is demonstrated or highly probable risk of COVID-19 infection, or there are continued incidents of medication theft during delivery), healthcare providers no longer have a duty to provide care. In practice, evaluating if the

risk is certain and significant is often up to individual healthcare staff. In these instances, healthcare providers should work with staff to:

a) Articulate and document why the risk of harm is intolerable (how the risk is certain and significant despite precautions); and
b) Develop an alternative plan to provide needed treatment and care to patients that helps them meet their needs while protecting staff safety (e.g., encouraging patients who are not symptomatic to come to pharmacies to pick up their prescriptions, following physical distancing and respiratory precautions)

Organizations must respect any staff concerns about safety and work with facility managers to develop alternative arrangements if medication delivery is deemed to put staff at certain and significant risk.

Pharmacists who are involved in medication delivery should refer to the CPBC Code of Ethics and PPP-71 for more information.

PATIENT EDUCATION

35. Are there any resources for patients that provide information on the eligibility criteria for pandemic prescribing?

The BCCSU has developed patient-facing information materials on the interim clinical guidance, including a lay summary and a postcard, which are available on the BCCSU website. These emphasize the importance of creating a treatment plan with their healthcare provider, which may include pandemic prescribing.

36. What kind of messaging can frontline workers (e.g., RNs, LPNs, pharmacists, social workers, peer support workers, and others) provide to patients about pandemic prescribing?

Frontline workers can provide information on public health measures and treatment options in the context of COVID-19. Patients can be advised that buying drugs or alcohol may put them in situations where they contact others, which could increase their risk of catching or spreading COVID-19. Over time, as the pandemic continues, the drug supply may also become more toxic and harder to access.Regarding pandemic prescribing, frontline workers can pass on the following messaging to patients:

> Your doctor or nurse practitioner can help you make a plan to reduce your contact with others, support your ongoing substance use care (if applicable) and/or reduce the need to purchase drugs or alcohol, and help prevent you from going into withdrawal. You and your health care provider (doctor or nurse practitioner) should discuss your needs and circumstances and

determine a care plan. Depending on your unique circumstances, options may include one or more of the following:

- Creating a treatment plan together
  - Reduce in-person contact for your care (e.g., providing longer prescriptions so you do not have to see your provider in person as often)
  - Explore options for fewer pharmacy visits (e.g., longer carries, where clinically appropriate)
  - Determine what to do if your pharmacy is closed so you can stay on your medication
- Treatment with medication (e.g., Suboxone for opioid use disorder or naltrexone for alcohol use disorder)
- Creating a plan to avoid withdrawal (e.g., self-managing alcohol intake)
- Prescribing non-traditional medications to replace illicit use (e.g., prescribed opioids, benzodiazepines, or stimulants)
- Connecting with other resources (e.g., a managed alcohol program or nicotine replacement therapy)

Frontline workers can also pass on information from public health officials, including reminding everyone to reduce their time in public spaces, reduce physical contact with others, and maintain a physical separation of 2 metres (i.e., two arms' lengths) distance. Refer to the BCCDC website for further guidance.

DISPENSING CONTROLLED SUBSTANCES

37. If my patient encounters challenges filling their prescription, what can be done?

Prescribers should ensure that they write full directions (including medication, dose, route of administration, frequency of dose, and maximum daily dose) on the prescription to meet prescription requirements for the pharmacy.

If a pharmacist has a conscientious or religious objection to the provision of a product or service, they must cooperate in the effective transfer of care initiated by the patient.

Refer to the CPBC website and Code of Ethics for more information.

38. How can daily witnessed ingestion (DWI) be done safely to reduce to risk of contact with patients who have been exposed to or have been diagnosed with COVID-19?

Please refer to the guidance for front line pharmacy staff provided by the CPBC in the frequently asked questions (FAQ) on their website.

39. What happens in the case of missed doses of controlled substances during the pandemic?

The prescriber and pharmacist should endeavour to communicate any changes to the patient care plan, including missed doses. Prescribers are encouraged to write a date range on each prescription,

in order to specify the intended prescription time period. If date ranges have not been written, pharmacists may consult with the prescriber before filling the prescription, where possible, and document the number of missed doses that would trigger cancellation of the prescription.

For missed doses of OAT and iOAT, requirements for pharmacists are provided in the Policy Guides to PPP-66 and PPP-67.

40. **What are the requirements for patient and pharmacist signatures on CPP forms and requirements for patient signatures on OAT part-fill accountability logs in the context of pandemic prescribing?**
Please refer to the guidance for patient signatures provided by the CPBC in the FAQ on their website.

41. **Can I use computer-generated refill authorization requests to refill OAT or other controlled drugs?**
A computer-generated refill authorization request cannot be used for refills of controlled drugs. A faxed copy of the CPP form must be sent as soon as it is ordered, and the original CPP form from the prescriber must be sent to the pharmacy as soon as reasonably possible.

Refer to the CPBC website for more information and specifics.

42. **Can prescriptions for narcotics, controlled substances, and targeted substances be transferred within provinces? What about across provinces?**
Currently in BC, prescriptions for narcotics, controlled substances, and targeted substances can be transferred multiple times within the province under the temporary Health Canada Section 56 exemption to the *Controlled Drugs and Substances Act*. In BC, benzodiazepines can be transferred to another province.

Refer to the CPBC website for more information and specifics.

43. **Can pharmacy technicians transfer prescriptions, receive transfers, or take verbal orders for controlled drugs?**
These tasks are not within the scope of practice for pharmacy technicians. Refer to the HPA Bylaws Schedule F, Part 1 (Community Pharmacy Standards of Practice), available here.

44. **Can pharmacists adapt prescriptions for controlled substances?**
Adapting prescriptions (including renewals) for controlled substances is not permitted in BC. BC pharmacists can offer an emergency supply of prescription drugs (including narcotics) for continuity of care under PPP-31, as appropriate.

Refer to the CPBC website for more information and specifics.

45. **What regulations exist around delivery of controlled substances during this pandemic?**
As of March 19, 2020, Health Canada has issued temporary exemptions under the Controlled Drugs and Substances Act that permit pharmacy staff to support the delivery of controlled medications.

Health Canada has also made Section 56 exemptions that permit nurses to transport narcotics, including OAT.

At this time, outreach workers are not able to deliver controlled substances in BC. For up-to-date information on CPBC requirements for delivery of OAT, refer to the CPBC website.

See the CPBC website for more information and specifics on supporting delivery of controlled drugs.

BC Centre on Substance Use
400-1045 Howe St
Vancouver BC V6Z 2A9
www.bccsu.ca