Decision Support Tool

For Registered Nurse Opioid Use Disorder Certified and Registered Psychiatric Nurse Opioid Use Disorder Certified Prescribing of Buprenorphine/naloxone

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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 buprenorphine/naloxone 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) sets out the activities that are within the scope of CP-OUD RNs and RPNs who are prescribing buprenorphine/naloxone (bup/nlx) 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, 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, Northern Health, and Interior Health.

SCOPE OF PRACTICE: BUPRENORPHINE/NALOXONE

Certified Practice OUD RNs and RPNs who have completed the education and training for buprenorphine/naloxone prescribing are authorized to prescribe bup/nlx as opioid agonist treatment (OAT). Certified Practice OUD RNs and RPNs may also prescribe adjunct medications (e.g., clonidine) for the management of withdrawal symptoms in the context of a bup/nlx induction. Certified Practice OUD RNs and RPNs who have not completed the required training to prescribe methadone or SROM must **refer** to an alternative OAT prescriber for all methadone or slow-release oral morphine (SROM) prescriptions. If after reviewing this DST and decision making is still unclear, please consult with an MD/NP or the 24/7 Addiction Medicine Clinician Support Line at 778-945-7619.

When to Consult or Refer

Doses	Co-occurring Central Nervous System (CNS) Depressant Use	Medications	Pregnancy or Chest-feeding	Youth		Contraindictions	Complex Acute illness or Chronic Disease
				15 or younger	16-18 years of age		
Consult for doses above 32mg/8mg	**Consult** or **refer** as outlined in Box 5 for prescribed or non-prescribed CNS depressant use (e.g., benzodiazepines, z-drugs, alcohol, and opioids) **Prescribed safer supply**: **Consult** if the client is on a prescribed safer supply (e.g., hydromorphone, sufentanil, fentanyl tablets or patch)	**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 the normal range, or albumin or total bilirubin is outside of the normal range See Box 7	**Refer**	**Consult**	**Consult** if known **Consult** to buprenorphine or any component of the formulation, currently taking monoamine oxidase inhibitors (MAOIs), or use within the past 14 days See Appendix 1	**Consult** or **refer** if known complex acute or chronic illness as 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.

OPIOID USE DISORDER

Diagnosis

Before CP-OUD RNs and RPNs prescribe OAT, clients should have a diagnosis made using the DSM-5-TR Clinical Diagnostic Criteria for Opioid Use Disorder to confirm the diagnosis and assess the severity of OUD.

Certified Practice OUD RNs and RPNs not trained or authorized to manage chronic pain, and cannot prescribe opioids for this purpose. Clients who do not meet the criteria for OUD and are seeking care for chronic pain should be referred to an MD/NP. Certified Practice OUD RNs and RPNs may prescribe OAT for individuals with an OUD who may have chronic pain. However, a referral to an MD/NP will be necessary for chronic pain management. If the existence of chronic pain makes the diagnosis of OUD unclear, consult with an MD/NP 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.

Note: Extended-release buprenorphine (Sublocade) prescribing is currently **out of scope** for CP-OUD RN and RPNs.

	Buprenorphine-based formulations		**Methadone**	**SROM**
	Buprenorphine/naloxone	**Extended-release buprenorphine (out of scope)**		
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

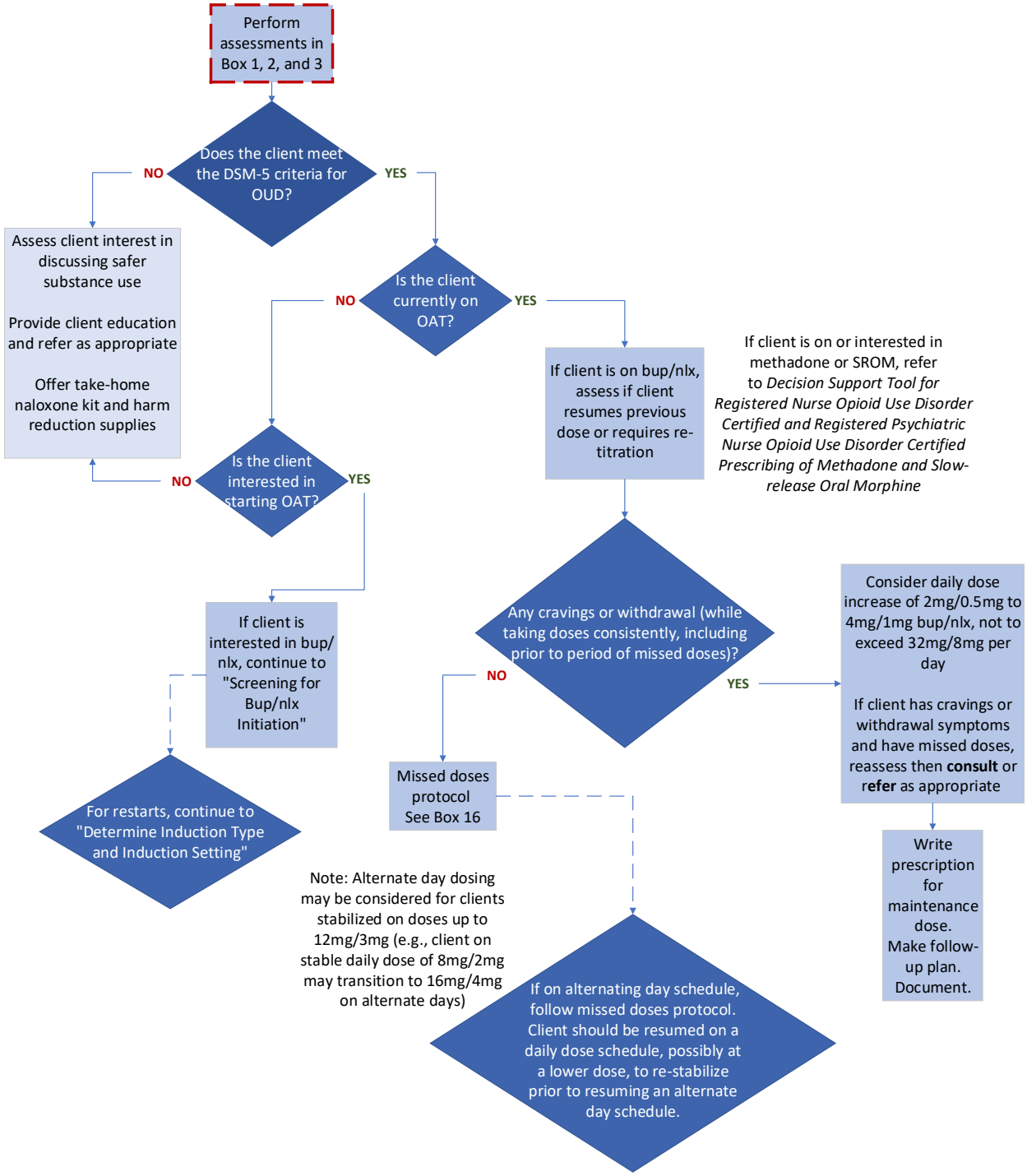
	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine (out of scope)		
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants	Low. Due to ceiling effect 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 (out of scope)		
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 Buprenorphine/naloxone Prescribing



DECISION SUPPORT TOOL

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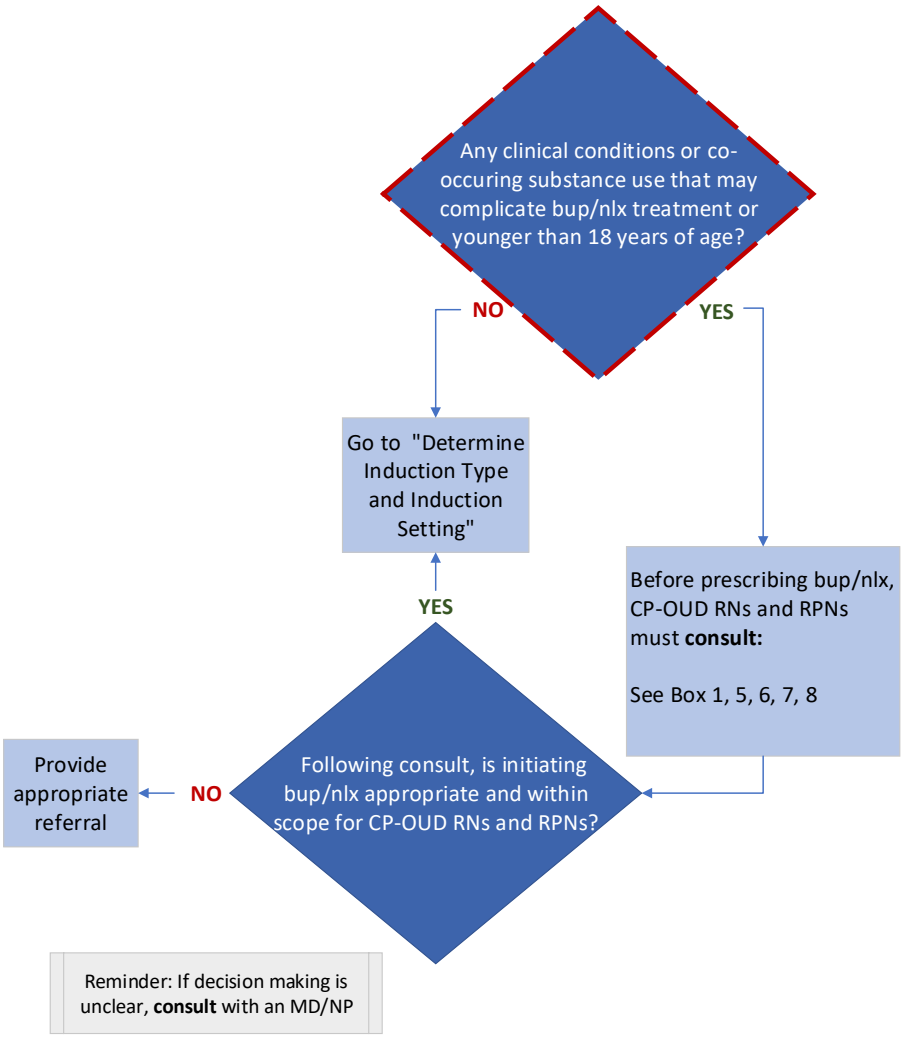
Screening for Buprenorphine/naloxone Initiation



DECISION SUPPORT TOOL

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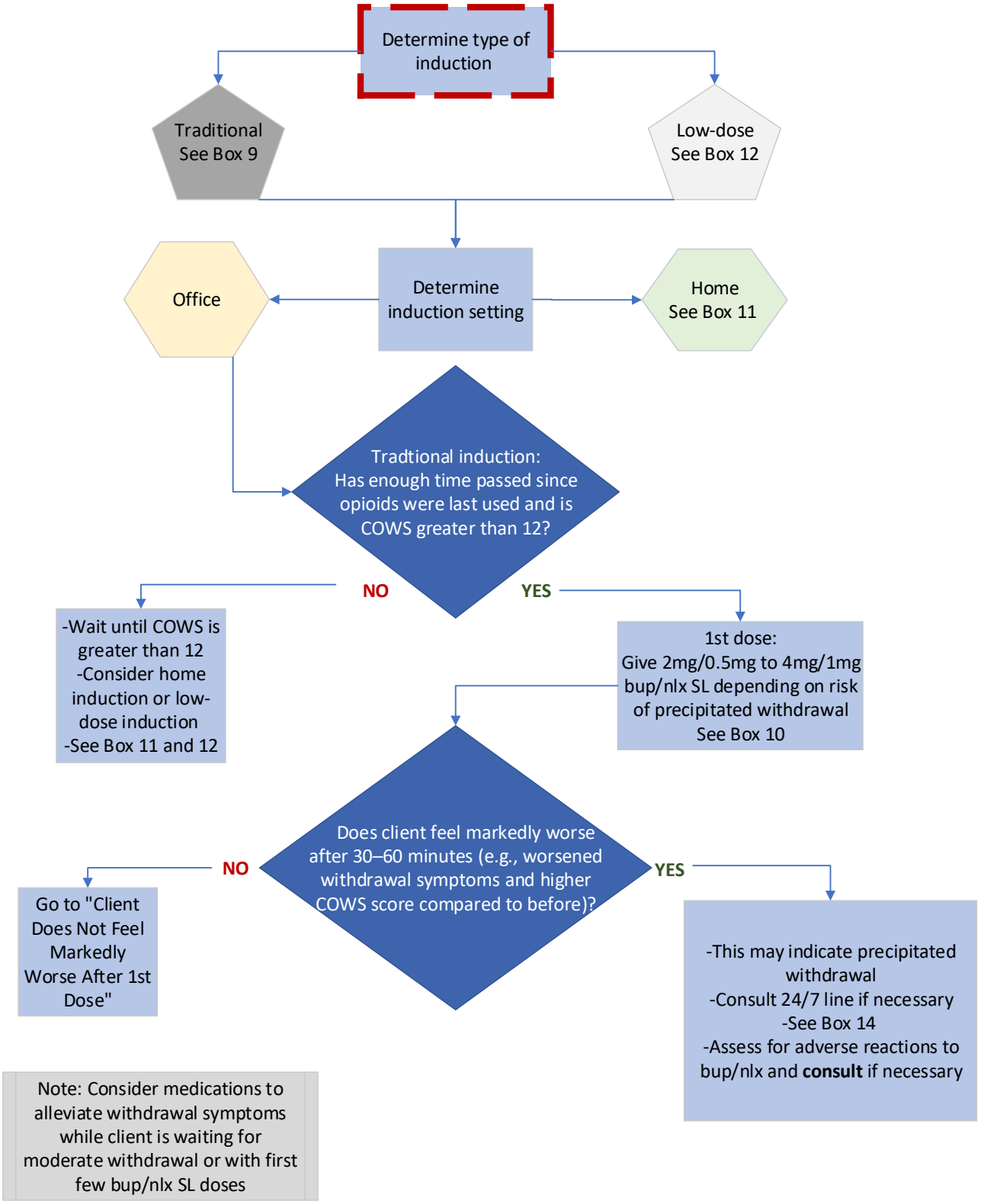
Determine Induction Type and Induction Setting



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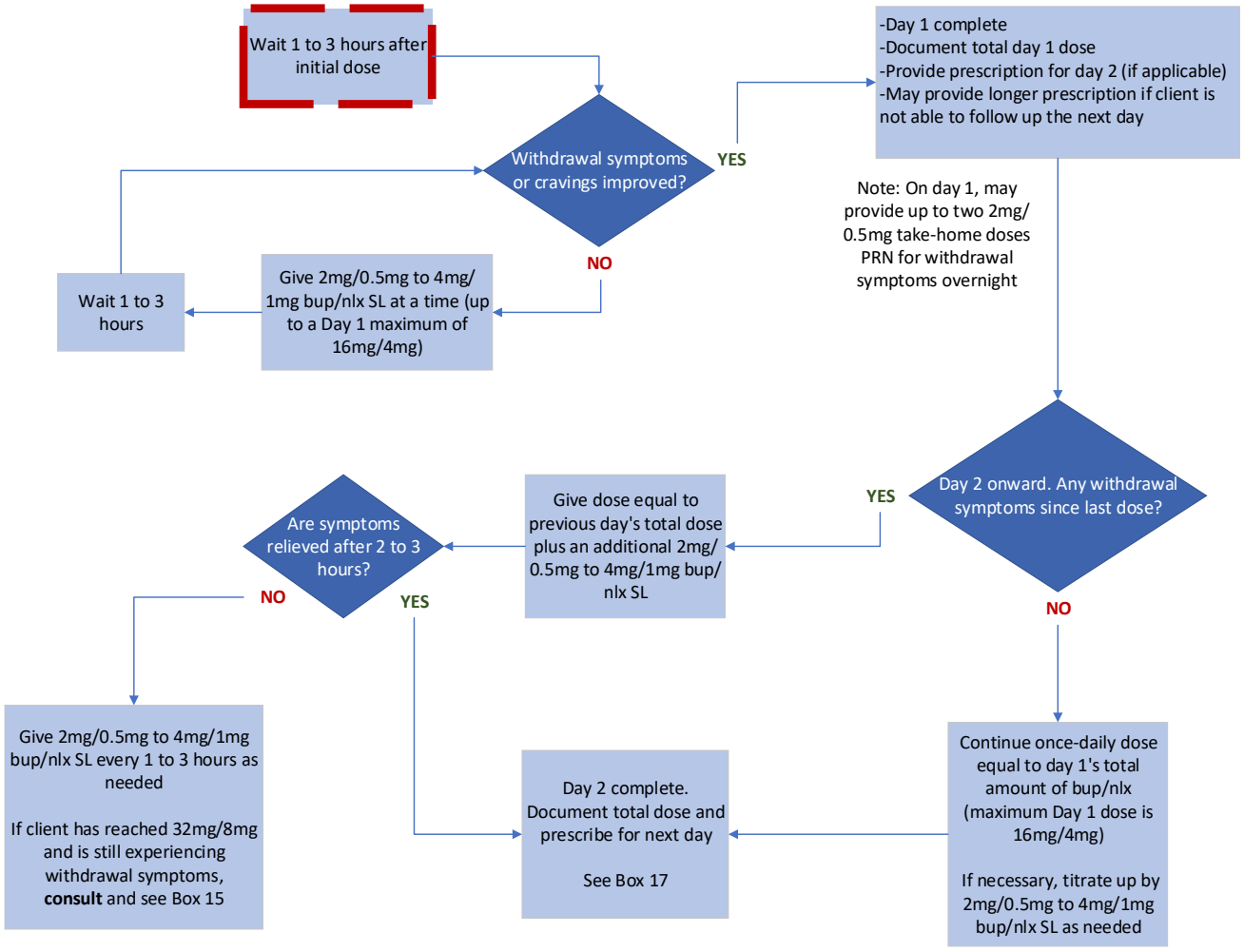
Client Does Not Feel Markedly Worse After 1st Dose



NEED TO KNOW

This section provides more detailed information on CP-OUD RNs and RPNs prescribing of bup/nlx 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 the case of suspected increased intracranial pressure, acute appendicitis, or any presentations that require immediate assessment). Individuals may also need an assessment by an MD/NP for primary care follow-up, which should be facilitated by the CP-OUD RN and 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 withdrawal symptoms and/or AUD **Consult** for initiations, continuations, titrations, or restarts of bup/nlx 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 • Electrocardiogram (ECG) and/or Holter monitoring confirmation • Echocardiogram (ECHO) • Physical assessment (e.g., irregular heartbeat, dizziness, syncope, crackles or rales, increased edema, or weight gain)	**Consult** for initiations, titrations, or restarts of bup/nlx 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 bup/nlx 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 bup/nlx, 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 bup/nlx, 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 bup/nlx 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 bup/nlx if the client is 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 bup/nlx, severe chronic or acute disease, allergy or hypersensitivity, severe respiratory distress, delirium tremens, or acute alcohol intoxication
4. Ensure adequate time has passed since the last opioid use to prevent precipitated withdrawal (for traditional inductions)

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
    - Determine any OAT medication prescribed and when it was last prescribed (if applicable)
    - 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 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)
4. Review substance use and past medical history with the client
5. Conduct physical assessment as needed
6. Assess the client's goals
    - Include treatment goals (e.g., immediate take-home doses), current housing, income, social support, cultural and wellness supports, identified strengths, and legal support
    - Connect with the health care team and refer as appropriate
7. Offer lab tests as appropriate (see Appendix 2)
    - Note that the continuation of OAT should not be delayed while waiting for bloodwork
    - Urine drug test, when clinically indicated (see Appendix 2)
    - Pregnancy test, when appropriate
8. Assess for new complications, such as adverse reactions
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. For traditional inductions, whether office or home-based, provide education on precipitated withdrawal and how to prevent it.

Medication Education

1. All clients should receive the following information about taking bup/nlx:
    - The tablet needs to fully dissolve under the tongue to work properly—**it will not be absorbed if swallowed**
    - Do not eat, drink, or smoke while the tablet is dissolving
    - It may take 10–15 minutes for the tablet to dissolve
    - The naloxone in the medication is not active if taken under the tongue, but may cause withdrawal symptoms if the medication is crushed and snorted or injected
2. Provide educational materials to the client as needed
    - See Appendix 4 for additional resources

Harm Reduction

3. 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
4. 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 any relevant supports (e.g., family, friends, support staff)
5. Harm reduction supplies
    - Offer safer use supplies and the related education to support infection prevention (e.g., bacterial, HIV, HBV/HCV)
6. 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: CONSIDERATIONS FOR BUP/NLX PRESCRIBING IN PREGNANCY

1. All clients of childbearing capacity who are sexually active and are considering starting bup/nlx or restarting bup/nlx should be offered a pregnancy test
   - Note that a pregnancy test is not required to prescribe bup/nlx
2. Certified Practice OUD RNs and RPNs can continue bup/nlx prescriptions for clients who are pregnant but should ensure 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 Guideline for the Clinical Management of Opioid Use Disorder and Treatment of Opioid Use Disorder Pregnancy–Guideline Supplement

BOX 7: CONSIDERATIONS FOR CLIENTS WITH POOR HEPATIC FUNCTION

1. Certified Practice OUD RNs and RPNs should screen clients for hepatic disease and order laboratory tests related to liver health (e.g., albumin, bilirubin, ALT, GGT) at the initiation of treatment and repeat 4 weeks after initiation
   - These tests are not required to initiate bup/nlx
2. If the client has severe hepatic dysfunction (e.g., elevated bilirubin levels) and is not currently taking bup/nlx, the CP-OUD RN or RPN must **consult** with an MD/NP using the 24/7 line or organizational pathway before initiating a bup/nlx prescription and document this consultation
3. If the client has severe hepatic dysfunction and is currently on or has previously taken bup/nlx, the CP-OUD RN or RPN may restart bup/nlx for the client but should **consult** with an MD/NP, either by using the 24/7 line or organizational pathway
   - This is not required before providing the prescription

BOX 8: CONSIDERATIONS FOR BUP/NLX PRESCRIBING 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 such as 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 9: CONSIDERATIONS FOR TRADITIONAL INDUCTION

1. The risks and benefits of all induction options should be discussed with the client to support informed decision-making

Table 1. Benefits and Risks of a Traditional Induction

Benefits	Risks
• Clients can typically reach a therapeutic dose within 1–2 days of medication initiation • May be preferable if there has been a significant period of time since the client's last opioid dose • May be preferable if the client is experiencing significant withdrawal symptoms • May be preferred by clients who have previous experience with traditional bup/nlx induction	• May not be preferred by clients who currently use fentanyl or other intermediate-and long-acting opioids (e.g., methadone) • Risk of precipitated withdrawal if the client does not wait after their last opioid use

2. Clients should be in moderate withdrawal before starting bup/nlx (i.e., COWS score greater than 12, SOWS score greater or equal to 17)
3. For office inductions: Clients should begin induction early in the day to allow enough time for dose titration throughout the day, if possible

Table 2. Suggested Wait time After Last Opioid Use

Medication	Suggested Wait Time
Heroin, oxycodone, hydromorphone	At least 12 hours
Slow-release oral morphine, fentanyl (confirmed, suspected, or uncertain)	At least 24 hours
Methadone	At least 48-72 hours

BOX 10: ASSESSING RISK OF PRECIPITATED WITHDRAWAL

1. There may be a higher risk of precipitated withdrawal with traditional inductions, compared to low-dose inductions
2. To minimize the risk of precipitated withdrawal in traditional inductions, ensure the appropriate amount of time has passed since last opioid use (see Box 9)
3. Clients who use fentanyl are at a higher risk of precipitated withdrawal
   - Start these clients at 2mg/0.5mg buprenorphine/naloxone
4. For clients at a lower risk of precipitated withdrawal (e.g., recently completed withdrawal management, known time of last opioid use, fentanyl-negative UDT), consider a higher starting dose of 4mg/1mg buprenorphine/naloxone

Table 3. Recommended Initial Buprenorphine/naloxone Doses Based on Risk of Precipitated Withdrawal

Indication	Starting Dose	Total Starting Dose
Concern about precipitated withdrawal	One 2mg/0.5mg buprenorphine/naloxone tablet	2mg/0.5mg buprenorphine/naloxone
Low risk of precipitated withdrawal	Two 2mg/0.5mg buprenorphine/naloxone tablet	4mg/1mg buprenorphine/naloxone

BOX 11: CONSIDERATIONS FOR HOME INDUCTION

1. Where safe and appropriate, CP-OUD RNs and RPNs can consider unobserved traditional induction or home induction as a means of addressing office attendance barriers and avoiding unnecessary disruptions to clients' daily lives (e.g., work, school, child-care, disability)
2. Prior to a home induction, CP-OUD RNs and RPNs should ideally be able to provide regular follow-up and support via telephone or video within regular clinic hours
   - Clients with previous experience taking bup/nlx may require less intensive support
3. Prior to initiating bup/nlx, discuss the risks and benefits of a home induction and document and obtain informed consent from the client
4. Provide clients with clinic/office contact information and in-person education and written instructions for dosing and timing, including the use of SOWS to assess withdrawal symptoms and determine when to start induction, if appropriate
   - Instructions should include:
     - See Box 4 for client education on how to take bup/nlx
     - Wait until moderate withdrawal occurs to prevent precipitated withdrawal (SOWS score greater or equal to 17 and sufficient time has passed since last opioid use)
     - Do not use opioids during initiation to relieve symptoms
     - Do not use sedatives during initiation (e.g., alcohol, benzodiazepines, or z-drugs)
     - Do not give up if symptoms persist after the initial doses
     - After taking 4 or more tabs, most people will start feeling improvement in withdrawal symptoms
     - Return to care (specialist, family physician, nurse practitioner, emergency department, nursing station, or health care setting) if symptoms of precipitated withdrawal or other adverse reactions develop and you are unable to cope

5. Instruct clients and/or caregivers to contact the office immediately in the event of any problems and to come in for clinical assessment as required
6. Provide the client with an education handout

BOX 12: CONSIDERATIONS FOR LOW-DOSE INDUCTIONS

1. Literature on low-dose bup/nx is limited, but growing evidence and clinical experience in BC highlight the important role of this approach
2. Low-dose inductions may be preferred by clients who currently use fentanyl or other intermediate-and long-acting opioids (e.g., methadone)
3. Low-dose inductions are usually started in a home setting, but the initial dose may be given in health care setting
4. Clients are not required to stop opioids or be in withdrawal before beginning a low-dose induction
5. The client slowly up-titrates low doses of bup/nlx while continuing prescribed or unregulated full-agonist opioid use until a therapeutic dose is reached, which typically occurs in community settings over 5–10 days
6. Clinicians may use clinical judgment as to whether their client requires a longer or shorter low-dose induction period
7. Clients may be prescribed a full agonist with their low-dose induction (see Box 13)
8. Follow the above considerations for home low-dose inductions, including:
    - Providing regular follow-up and support
    - Discussing risks and benefits
    - Obtaining consent
    - Providing clients with clinic information
    - Providing verbal and written instructions for dosing and timing, taking the medication correctly, and contacting the clinic if there are any problems during the induction
9. The low-dose induction protocol BID may be preferred by some individuals due to the consistent twice-daily schedules

Table 4. Sample Low-dose Induction Protocol

Day	Buprenorphine/naloxone dose	Other Opioids
1	0.5mg/0.125mg SL BID	Continue use
2	0.5mg/0.125mg SL TID	Continue use
3	1mg /0.25mg SL BID	Continue use
4	2mg /0.5mg SL BID	Continue use
5	2mg /0.5mg SL TID	Continue use
6	4mg /1mg SL TID	Continue use
7	12mg /3mg SL daily	Stop use

Table 5. Sample Low-dose Induction Protocol BID

Day	Buprenorphine/naloxone dose	Other Opioids
1	0.5mg/0.125mg SL BID	Continue use
2	1mg/0.25mg SL BID	Continue use
3	2mg/0.5mg SL BID	Continue use
4	3mg/0.75mg SL BID	Continue use
5	4mg/1mg SL BID	Continue use
6	6mg/1.5mg SL BID	Continue use
7	8mg/2mg SL BID	Continue use
8	16mg/4mg SL daily	Stop other opioid use

BOX 13: FULL AGONIST CO-PRESCRIPTION WITH LOW-DOSE INDUCTIONS

1. If clinically indicated, co-prescribing a full agonist (e.g., methadone or SROM) during a low-dose induction can help reduce or eliminate clients' reliance on the unregulated drug supply and reduce the risk of drug poisonings while titrating bup/nlx
2. Clients may be prescribed either methadone or SROM with a low-dose bup/nlx induction
3. When co-prescribing a full agonist (either methadone or SROM), it is out of scope for CP-OUD RNs and RPNs to titrate the full agonist
4. Methadone and SROM are full agonists at the mu receptor, which means that no wash-out period is required
5. Doses for methadone and SROM are dependent on the client's opioid tolerance (e.g., a client with a known very high tolerance may be prescribed 300mg of SROM). More information on full agonist dosing can be found in the Decision Support Tool for Registered Nurses Opioid Use Disorder Certified and Registered Psychiatric Nurses Opioid Use Disorder Certified Prescribing of Methadone and Slow-release Oral Morphine and the Guideline for the Clinical Management of Opioid Use Disorder

Table 6. Sample Full Agonist Co-prescription with Low-dose Buprenorphine/naloxone Induction for a Client with a Known Tolerance

Day	Methadone		SROM		Buprenorphine/naloxone
1	30mg PO daily		200mg PO daily		0.5mg/0.125mg SL BID
2	30mg PO daily		200mg PO daily		1mg/0.25mg SL BID
3	30mg PO daily		200mg PO daily		2mg/0.5mg SL BID
4	30mg PO daily	OR	200mg PO daily	AND	3mg/0.75mg SL BID
5	30mg PO daily		200mg PO daily		4mg/1mg SL BID
6	30mg PO daily		200mg PO daily		6mg/1.5mg SL BID
7	30mg PO daily		200mg PO daily		8mg/2mg SL BID
8	stop		stop		12mg/3mg SL BID
9 and onwards	stop		stop		24mg/6mg SL OD

BOX 14: MANAGING PRECIPITATED WITHDRAWAL DURING BUP/NLX INDUCTION

1. Explain to the client what has occurred
2. Discuss the options below for management, taking into consideration the client's preference
3. Call 24/7 line at 778-945-7619
4. Obtain informed consent for the agreed-upon option
5. Offer non-opioid adjuncts to treat withdrawal symptoms (e.g., clonidine, acetaminophen, dimenhydrinate, loperamide)

Option 1: Continue induction

- Administer additional doses of 2mg/0.5mg bup/nlx every 1–2 hours
- Continue up to the Day 1 maximum (16mg/4mg bup/nlx) or until withdrawal symptoms are resolved

Option 2: Delay induction

- Consider waiting a few hours to allow the full agonist to clear opioid receptors before administering the next bup/nlx dose
- Offer non-opioid adjuncts to treat withdrawal symptoms as needed
- Continue until withdrawal symptoms are resolved

Option 3: Stop induction

- Provide reassurance that symptoms will resolve as opioid withdrawal runs its course
- Offer to discuss a plan for a future induction attempt or an alternate form of OAT

Option 4: High-dose buprenorphine/naloxone (Out of scope for CP-OUD RNs and RPNs)

- Involves treating precipitated withdrawal with additional doses of buprenorphine/naloxone in close succession, typically ranging from 8mg/2mg to 16mg/4mg
- **Refer** to MD/NP. This option is based on clinical experience and therefore some prescribers may not be comfortable with this approach

BOX 15: MEDICATIONS TO ALLEVIATE WITHDRAWAL SYMPTOMS

Prior to the first dose or during the first few doses of bup/nlx, consider providing medications to alleviate opioid-related withdrawal symptoms

- Offer non-opioid adjuncts to treat withdrawal symptoms

Clonidine

- 0.1–0.2mg PO every 6 hours PRN
- Maximum 0.8mg/day
- Check blood pressure and avoid if the client is hypotensive

Acetaminophen

- 325–1000mg PO every 4 to 6 hours PRN
- Maximum 4,000mg/day; 2,000mg for older adults or those with liver impairment

Dimenhydrinate

- 50–100mg PO every 6 hours PRN

Ibuprofen

- 400mg PO every 4 hours PRN
- Maximum 3,200mg/day

Loperamide

- 2–4mg PO every 6 hours PRN
- Maximum 16mg/day

BOX 16: ASSESSING CLIENTS WHO HAVE MISSED DOSES

1. Review BPMH and PharmaNet
2. Ask the client if they have missed bup/nlx doses
   - If the client reports missing doses, ask the client empathetically why they have missed doses
   - Clients who report missed doses may require additional support (e.g., consider take-home dosing if daily witnessed ingestion is a barrier due to employment or school)
3. Ask the client about any ongoing substance use
4. Ask for UDT, if appropriate
5. Document findings
6. Inform other members of the client's care team
7. If the client is pregnant, **consult** another prescriber before restarting. If the client has severe hepatic dysfunction, consultation is recommended but not required before the restart
8. Follow missed dose protocol below
9. The pharmacist will cancel the prescription after 6 missed doses (without return to full agonist use) and after 4 missed doses (with return to full agonist use)

Table 7. Missed Doses of Buprenorphine/naloxone

Missed days (consecutive)	Suggested dose adjustment
Without return to full opioid agonist use	
5 or fewer	No change in dose is required
6 or more	Re-titration is required, hold bup/nlx dose pending virtual or in-person assessment
With return to full opioid agonist use	
1–3	No change in dose is required, it is likely safe to continue bup/nlx without re-induction
4	Hold dose pending virtual or in-person assessment and discuss the risk of precipitated withdrawal and weigh them against the benefits of continuing bup/nlx
5 or more	Hold dose pending virtual or in-person assessment, new induction may be required (see Box 9 for traditional induction and Box 12 for low-dose induction)

Alternate day schedule

- For missed doses with an alternating day schedule, follow missed doses protocol above. Individuals should be returned to a daily dose schedule, possibly at a lowered dose, to re-stabilize prior to resuming an alternating day schedule.

BOX 17: STABILIZATION AND FOLLOW UP

1. Once the client is stabilized on bup/nlx, continue to assess at least every 1–2 weeks with the option to decrease follow-up visits 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
   - Health promotion
3. Urine drug tests should be done at per 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 bup/nlx 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. Evidence of diversion (e.g., UDT negative for buprenorphine without missed doses in PharmaNet) should prompt re-engagement with the client to re-assess treatment plan
7. If doses have been missed, follow missed doses protocol (see Box 16)

BOX 18: LABORATORY AND POINT-OF-CARE TESTS

1. Certified Practice OUD RNs and RPNs may order a number of laboratory and point-of-care tests to support decision-making and for health promotion in OUD care
2. These may be ordered at baseline and in follow-up
3. See Appendix 2 for a list of these tests and information on when to consult with an MD/NP and Box 7 for considerations for bup/nlx and hepatic function

BOX 19: CONSIDERATIONS FOR TAKE-HOME DOSES OF BUP/NLX

1. Take-home dosing should be considered for all clients who meet the following criteria:
    - Clinical and psychosocial stability
        - Generally, the indications of clinical and psychosocial stability include:
            - ◊ Ability to attend appointments
            - ◊ Absence of unstable psychiatric comorbidities (e.g., psychosis, suicidality)
            - ◊ Absence of severe behavioural issues at the clinic
            - ◊ Absence of severe sedation
            - ◊ Absence of high-risk or uncontrolled substance use patterns that cause frequent drug poisoning or blackouts
        - Point-of-care assessment of stability is client-specific, depending on each client's circumstances and needs and how they change over time
    - Ability to safely store medication (access to a secure lockbox or cabinet)*
2. Take-home dosing may be considered immediately for clients who meet the criteria

* Discuss the importance of keeping the medication safe and avoiding misplacing the medication with those who do not have access to a secure lockbox or cabinet (e.g., people experiencing homelessness).

BOX 20: CONSIDERATIONS FOR BUP/NLX TAPER

Evidence supporting best practices for OAT tapering is lacking

- Due to the high likelihood of the client's return to unregulated opioid use, OAT tapers are generally not recommended
- 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
- If a client requests a bup/nlx taper:
  - **Consult** an MD/NP
  - Listen to the client's concerns and rationale for requesting the taper
  - Provide education as needed, and 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, and support and referrals to appropriate services
  - Encourage the client to connect with their prescriber if concerns of substance use arise
  - A relapse prevention plan should be collaboratively developed and implemented after a discussion with the client

BOX 21: DOCUMENTATION

Documentation when following this decision-making tool should include:

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

Example SOAP note**:**

8. 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
9. 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)
   - Physical and mental status assessment
   - Client's general appearance (e.g., acutely intoxicated, injection marks, diaphoresis, tremors)
10. Assessment
    - Clinical impression and diagnosis (e.g., opioid use disorder: client unstable as evidenced by ongoing unregulated opioid use)

11. 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 22: ACTING ON A CERTIFIED PRACTICE OUD RN OR RPN'S ORDER

- In some health care settings where bup/nlx is wardstock, prescribing, dispensing, and administering bup/nlx may occur
- 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 bup/nix

BOX 23: 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. 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

3. 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 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
Opioid antagonists	Naltrexone	**Contraindicated** Blocks the pharmacological effects of buprenorphine, which can lead to precipitated withdrawal	Avoid co-prescribing opioid antagonists with OAT The client may require a different medication (e.g., acamprosate for AUD)
CYP3A4 inhibitors	Azole antifungals Macrolide antibiotics Protease inhibitors	May require buprenorphine dose reduction or a change in antibiotic or antifungal	Closely monitor the client **Consult** with pharmacy or other resources prior to prescribing if uncertain
CYP3A4 inducers	Carbamazepine Phenobarbital Phenytoin Rifampicin	May result in under treatment of OUD May require dose adjustment of CYP3A4 inducer or buprenorphine	Closely monitor the client **Consult** with pharmacy or other resources prior to prescribing if uncertain

Common drug–drug interactions		Comment	Action for CP-OUD RN and RPN
Category	Examples		
Serotonergic medications	**SSRIs** • Citalopram • Escitalopram • Fluoxetine • Paroxetine • Sertraline • Vilazodone **SNRIs** • Desvenlafaxine • Duloxetine • Levomilnacipran • Milnacipran • Venlafaxine **Tricyclic Antidepressants** • Isocarboxazid • Phenelzine • Tranylcypromine	Theoretical increase in the risk of serotonin syndrome	Closely monitor the client

Note on cytochrome P450 3A4

- Buprenorphine is metabolized by the cytochrome P450 3A4 (CYP3A4) enzyme system
  - Drugs that are known to inhibit or induce CYP3A4 have the potential to diminish or enhance buprenorphine metabolism–**buprenorphine doses rarely need to be adjusted**

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 That Have Implications for OAT Care Performed prior to initiation when feasible, should not be a barrier to starting care	
Blood Complete blood count Creatinine/eGFT—serum/plasma Prothrombin time/INR	• **Consult** an MD/NP if outside the normal ranges as per organizational processes to determine a plan of care
Liver function Albumin Alanine aminotransferase (ALT) Gamma glutamyl transferase (GGT) Bilirubin	• The 24/7 line can be consulted in the case of severe hepatic dysfunction (e.g., ALT or GGT greater than 3 times the upper limit of normal, any elevation in bilirubin) and concern around bup/nlx prescribing • Abnormal liver function results that are less than 3 times the upper limit of normal should not delay the prescription of bup/nlx, but the client should be connected to primary care for follow up

Laboratory Test	Follow-up for CP-OUD RNs and RPNs
Tests for Health Promotion, to be Offered as Clinically Indicated Additional tests that may be appropriate following treatment initiation	

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 BC-CDC'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 BCCDC)

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
- 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 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
BID: twice a day
Bup/nlx: buprenorphine/naloxone
CNS: central nervous system
COWS: Clinical Opiate Withdrawal Scale
CP-OUD: Certified Practice Opioid Use Disorder
CYP: cytochrome
CYP3A4: cytochrome P450 3A4
DST: decision support tool
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
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)