PRECEPTORSHIP WORKBOOK:
ACUTE CARE SETTINGS

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

About the British Columbia Centre on Substance Use

The BC Centre on Substance Use (BCCSU) is a provincially-networked organization with a mandate to develop, help implement, and evaluate evidence-based approaches to substance use and addiction. The BCCSU seeks to improve the integration of best practices and care across the continuum of substance use through the collaborative development of evidence-based policies, guidelines, and standards. With the support of the Province of BC, the BCCSU aims to transform substance use policies and care by translating research into education and care guidance, thereby serving all British Columbians.

The BCCSU seeks to achieve these goals through integrated activities of its three core functions: research and evaluation, education and training, and clinical care guidance.

Research and Evaluation—Leading an innovative multidisciplinary program of research, monitoring, evaluation and quality improvement activities to guide health system improvements in the area of substance use.

Education and Training—Strengthening addiction medicine education activities across disciplines, academic institutions, and health authorities, and training the next generation of interdisciplinary leaders in addiction medicine.

Clinical Care Guidance—Developing and helping implement evidence-based clinical practice guidelines, treatment pathways, and other practice support documents.

Disclaimer for Health Care Providers

The recommendations and key takeaways from this workbook reflect the recommendations published by the BCCSU, the BC Ministry of Health, and the BC Ministry of Mental Health and Addictions in *A Guideline for the Clinical Management of Opioid Use Disorder (2023)*. When exercising clinical judgement in the treatment of opioid use disorder, health care professionals in the province of British Columbia are expected to take the guideline recommendations fully into account, alongside the individual needs, preferences, and values of people receiving care and their families, and in light of their duties to adhere to the fundamental principles and values, as outlined in the Canadian Medical Association Code of Ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability, as well as the required standards for good clinical practice of the College of Physicians and Surgeons of British Columbia (CPSBC) or the British Columbia College of Nurses and Midwives (BCCNM) and any other relevant governing bodies.

Case studies and prescriptions

The case studies and prescriptions in this workbook are provided as learning examples only. Application of the recommendations presented both in this workbook and in *A Guideline for the Clinical Management of Opioid Use Disorder (2023)* do not override the responsibility of health care professionals to make decisions appropriate to the circumstances of each individual, in consultation with that person and their guardian(s) or family members, and, when appropriate, external experts (e.g., speciality consultation).

Table of Contents

Welcome

Congratulations! You have completed the online modules in POATSP. This is the first step in becoming an opioid agonist treatment prescriber. This workbook is designed to help apply and consolidate your learning. The cases contained in this workbook provide an overview of commonly-encountered clinical scenarios and ask you to apply the skills and knowledge you have just gained in the online course.

Education and Training Pathway

The BCCSU education and training requirements for physicians or nurse practitioners prescribing oral OAT in acute care settings in British Columbia include:

Online modules in POATSP

Workbook for acute care settings (this workbook)

One 8-hour day of in-person preceptorship

Note: If you are a registered nurse (RN) or registered psychiatric nurse (RPN), you are currently accessing the incorrect workbook for your scope of practice.

Please email bccsu_education@bccsu.ubc.ca to obtain the RN/RPN Prescribing Workbook.

Process

1. Complete the required modules in the appropriate online **POATSP** course stream (8–10 hours)
2. Obtain a **POATSP Certification of Completion** in the online platform
   When accessing the certificate, instructions are provided to:
   - Schedule a **preceptorship**
   - Access this workbook
3. Schedule a preceptorship
   - Please review the preceptor contact sheet and directly communicate with a chosen preceptor to select mutually agreeable date(s)
4. Complete this workbook
5. Attend the in-person preceptorship
6. Complete any additional learning at the discretion of the preceptor
7. Sign the **Safe Prescribing Agreement**, (page 40)
8. Complete the online **Preceptorship Form**, (page 41)
   - An online survey tool to report that the preceptorship has been completed

Once these steps above are completed by the preceptee, the preceptor will need to:

9. Complete **Preceptor Review Evaluation** (sent via email to the selected preceptor)

The BCCSU will then issue a **Proof of Completion** letter to you via email. The next steps for ordering prescription pads are outlined in this letter.

Preceptorship Goals

The goal of the POATSP preceptorship is to promote understanding and application of the educational components contained within the online platform. During the preceptorship, the completed workbook will be reviewed together with the preceptor.

In order to complete the preceptorship requirements, preceptees must have:

1. Completed the required online modules in the POATSP course stream.
2. Secured a preceptorship.
3. Completed this workbook before the scheduled preceptorship.
4. Report attending this preceptorship through the online **Preceptorship Form**.

Role of preceptors

Preceptors must:

1. Review the workbook.
2. Ensure the **Safe Prescribing Agreement** is discussed and signed.
3. Complete the **Preceptor Review Evaluation** to provide an assessment and sign-off of the preceptees, based on competencies demonstrated and articulated through the preceptorship.

Glossary

Buprenorphine/naloxone
A combination of buprenorphine and naloxone in a 4:1 ratio. Buprenorphine is a long-acting synthetic opioid that acts as a partial mu (μ) opioid receptor agonist, and naloxone is an opioid receptor antagonist. In Canada, buprenorphine/naloxone is available in two forms: a sublingual tablet, which is covered by PharmaCare, and a buccal film which is not currently covered in BC. Naloxone has poor oral bioavailability when swallowed or administered sublingually, and is included to deter injection and insufflation (snorting). When buprenorphine/naloxone is taken sublingually as directed, the naloxone component has negligible effects and the therapeutic effect of buprenorphine dominates.

COWS
Clinical Opiate Withdrawal Scale

DSM-5-TR
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision

DWI
Daily witnessed ingestion

Extended-release Buprenorphine
Extended-release buprenorphine is administered monthly via abdominal subcutaneous injection for the management of moderate to severe opioid use disorder. It is currently available in Canada under the brand name Sublocade for individuals who have been clinically stabilized on at least 8mg to 24mg of sublingual buprenorphine/naloxone for a minimum of 7 days.

Low-dose induction
An induction strategy for buprenorphine/naloxone where the person receiving care is prescribed small initial doses (e.g., 0.5mg/0.125mg buprenorphine/naloxone), which are slowly up-titrated while the person continues using prescribed or unregulated opioids. The other opioids are abruptly stopped or tapered down once a therapeutic buprenorphine/naloxone dose is achieved. Low-dose inductions typically occur in community settings over a 5–10-day period; however, clinicians may use clinical judgment as to whether the person requires a longer or shorter low-dose induction period. The low-dose protocols provided in this workbook are given as examples of what is currently used in practice, and are subject to change as more information becomes available.

Methadone
A long-acting synthetic opioid that acts as a full mu (μ) opioid receptor agonist. In Canada, it is most frequently administered as an oral solution. It has a half-life of approximately 24 to 96 hours and is well absorbed. Methadone tablets are also available in a limited context (e.g., for travel).

OAT
Opioid agonist treatment

OUD
Opioid use disorder

SL
Sublingual

Slow-release oral morphine (SROM)
A 24-hour formulation of morphine, a full agonist at the mu (μ) opioid receptor. It is taken orally once per day. It is available in Canada under the brand name Kadian and is provided in BC to treat opioid use disorder.

Traditional buprenorphine/naloxone induction
An induction strategy for buprenorphine/naloxone that requires a wash-out period of full agonists (whether prescribed or unregulated) and for the person receiving care to be in moderate withdrawal at the time of medication initiation, in order to prevent precipitated withdrawal. A traditional induction can be conducted in clinic or hospital setting or as a "home induction."

UDT
Urine drug testing

Preceptor Checklist

Assess the preceptee for their knowledge and ability in the sections below:

Checklist item	✓
Prescriber approach	
Obtaining feedback from the person receiving care	
Use of trauma- and violence-informed care	
Use of culturally safe, anti-racist, person-centered, and harm-reduction oriented care	
Continuity of care planning	
Awareness of the potential benefits of OAT	
Reduced or discontinued opioid use	
Reduced risk of drug poisoning and other drug-related harms	
Reduced or discontinued use of other psychoactive substances	
Improved mental and physical health	
Reduced involvement with the criminal justice system	
Improved living situation	
Improved social and personal relationships	
Improved vocational and employment opportunities	
Connection with primary care	
Assessment before prescribing OAT	
Past medical history Review, if available	
PharmaNet review Access to the person's PharmaNet records Review for current prescription of OAT medications and medications with potential drug–drug interactions	
Biopsychosocial assessment Prior substance use treatment (pharmacotherapy, withdrawal management, bed-based or inpatient treatment, support groups, counselling, return to use prevention), legal history and current legal issues, source of income or financial concerns, employment history, family history, social and emotional supports, additional areas of concern for the individual (e.g., sexual abuse, violence, child at risk, high-risk sex)	
Full medical history Review medical history, including psychiatric history, surgical history, medications, past experience with OAT, allergies, systems, health in general, and any other health-related concerns	
Physical exam Check for intoxication, withdrawal, any signs of recent injection drug use	

Harm reduction Education on the importance of using sterile equipment (e.g., cookers, syringes, pipes), and safer use strategies (e.g., accessing supervised consumption and overdose prevention sites, take-home naloxone kit, using the Lifeguard app or Brave app, accessing drug checking services, performing a test dose, and recommending use with a person who is not using) Discuss a safety plan to prevent drug poisoning and what to do if they return to use	
Diagnose OUD using the DSM-5-TR	
Substance use history Type of substance, route of administration, age of first use, frequency of drug use and amount (in points and/or dollar value), last use, withdrawal symptoms, drug poisoning history, sedative use	
Laboratory assessment and examinations Performing a urine drug test Ordering liver enzyme tests (ALT, GGT, total bilirubin, albumin); renal function tests (creatinine and estimated glomerular filtration rate); complete blood count, international normalized ratio (INR); HIV test; hepatitis serology (B, C); sexually transmitted infection screen; pregnancy test, if applicable; ECG, if indicated	
Reproductive health, including contraception	
Specific populations Considerations for adolescents, individuals who are pregnant, and individuals with poor hepatic function	
Coverage PharmaCare coverage (or private insurance) for OAT Completing the Plan G form	
Urine drug testing	
Informed consent	
Practical strategies for incorporating person-centred care	
Planning UDTs (scheduled, supervised)	
Awareness of best practices of UDT—including non-punitive approaches to screening and understanding limitations of UDTs	
Review circumstances where urine drug testing may be in indicated, and review suggested testing frequency	
Collection procedure	
Difference between immunoassay test and confirmatory lab testing	
Substances for inclusion	
Interpreting UDT results	
Managing unexpected results	
Preparing to prescribe OAT	
Writing prescriptions	
Safe storage of prescription pads	

Prescribing OAT	
Buprenorphine/naloxone	
Safety: Drug–drug interactions (e.g., naltrexone), comorbid conditions, alcohol or other sedative use	
Plan for induction— low-dose or traditional (office or home-based)	
Managing precipitated withdrawal	
Initial dosing recommendations	
Therapeutic dose (individually titrated up to the point of cessation of unregulated opioid use)	
Treatment plan (i.e., take-home doses, witnessed doses, or a combination)	
Missed doses	
Writing prescriptions Prescription length: Current practice is to write a prescription for at least 7 days depending on clinical context and stability. Encourage follow-up before the end date of the prescription for dose adjustments	
Monitoring and follow-up, including documenting response to medication	
Methadone	
Safety: QT prolongation, drug–drug interactions (e.g., naltrexone, medications with the potential to prolong the QT interval), comorbid conditions, alcohol or other sedative use	
Initial dosing recommendations	
Therapeutic dose (individually titrated up to the point of cessation of unregulated opioid use)	
Treatment plan (i.e., witnessed doses, take-home doses, or a combination)	
Missed doses	
Writing prescriptions Prescription length: Current practice is to write a prescription for at least 7 days depending on clinical context and stability. Encourage follow-up before the end date of the prescription for dose adjustments	
Monitoring and follow-up, including documenting response to medication	
Slow-release oral morphine	
Safety: Drug–drug interactions, comorbid conditions, alcohol or other sedative use	
Initial dosing recommendations	
Therapeutic dose (individually titrated up to the point of cessation of unregulated opioid use)	
Treatment plan (i.e., witnessed doses, take-home doses, or a combination)	
Missed doses	
Medication shortages	
Writing prescriptions Prescription length: Current practice is to write a prescription for at least 7 days depending on clinical context and stability. Encourage follow-up before the end date of the prescription for dose adjustments	
Monitoring and follow-up, including documenting response to medication	

Strategies for safe prescribing	
Review and sign Safe Prescribing Agreement (page 40 of this workbook)	
Criteria for initiating take-home dosing, including secure storage of medication	
Take-home dosing schedule	
Prescription for take-home doses	
Monitoring take-home dosing	
Re-assessment of take-home dosing	
Psychosocial and community connection	
Community services and supports (e.g., access to social workers)	
Psychosocial treatment intervention groups (e.g., SMART Recovery, Seeking Safety)	
Peer-based support groups (e.g., 12-step facilitation programs)	
Support network	
Housing	
Recommended local resources	
Communication and collaboration	
Communicating with pharmacies	
Access to addiction medicine specialists (24/7 Addiction Medicine Clinician Support Line, RACEapp+, hospital-based Addiction Medicine Consult Team, Rapid Access Addiction Clinic)	
Ensuring continuity of care planning (e.g., referral pathways)	
Documentation	
Person receiving care meets the DSM-5-TR criteria for OUD	
Baseline assessment	
Discussion of avoiding alcohol and CNS depressants	
PharmaNet review	
Treatment plan, including individual goals and continuity of care	
Medication selection and rationale	
Medication prescribed, dose, indication, education	
Response to medication	
Length of prescription	
Follow-up plan	
Harm reduction and education	
Other relevant information for the care team	
Any other consultation or referral related to the individual's care	
Precautions	
Tapering individuals off of OAT	
Withdrawal management alone is not advised	
Safety issues with concurrent sedative use (e.g., alcohol, benzodiazepines)	
Billing[1]	
Assessment for OAT induction: 13013	
Opioid agonist treatment induction: 13014	
Opioid agonist treatment billing: 00039	
Urine drug testing billing: 15039	

1 These billing codes are specific to family physicians

Cases

This workbook contains 8 case studies focused on individuals receiving or seeking treatment with OAT medications. Each case has a brief description followed by guiding questions, which are designed to guide reflection on the clinical scenario presented and how to manage the person receiving care including, when appropriate, writing a prescription.

Please note that these case scenarios were created to represent a wide variety of clinical scenarios and are for illustrative purposes only. They do not represent real people. Completion of this workbook is intended as a learning exercise. If you have any questions or require clarification while reviewing these cases, please reach out to your preceptor for guidance.

Case 1: Moshe

Low-dose buprenorphine/naloxone induction

Date: May 16, 2023

Moshe, a 37-year-old man, was admitted to hospital following acute lower abdominal pain, fever, and vomiting. He underwent an emergency laparoscopic appendectomy. Perioperatively, he is prescribed morphine for pain and withdrawal symptoms. Post-operatively, he is given non-opioid analgesia for pain management, with opioid analgesia prescribed as needed. He is likely to be discharged in 3 days, depending on his recovery.

Moshe has a mild opioid use disorder. He started using unregulated opioids approximately 6 months ago, after he was prescribed oxycodone tablets following an injury at work. Since his prescription ended, he has been obtaining oxycodone through a friend.

Following a discussion of the treatment options, Moshe would like to start treatment for opioid use disorder and agrees to start buprenorphine/naloxone treatment.

.

Name: Moshe A Goldmann
Date of birth: September 9, 1985
Personal health number: 9123 456 789
Address: 123 Main Street, Victoria, BC

Case 1: Questions

1. How does Moshe's hospital admission for an emergency surgery present an opportunity to engage him in OUD care?

2. What is the purpose of including naloxone in the buprenorphine/naloxone formulation?

3. What assessments should be performed before initiating buprenorphine/naloxone?

4. What method of buprenorphine/naloxone induction would be most suitable for Moshe? Explain the induction method.

Moshe starts a buprenorphine/naloxone low-dose induction while in hospital.

5. What buprenorphine/naloxone doses can be prescribed for days 1–3 of a 7-day low-dose induction?

Day 1:_____mg/_____mg buprenorphine/naloxone _____ times a day
Day 2:_____mg/_____mg buprenorphine/naloxone _____ times a day
Day 3:_____mg/_____mg buprenorphine/naloxone _____ times a day

Moshe is discharged on May 18, 2023 (Day 3 of his low-dose buprenorphine/naloxone induction) and receives both Day 3 buprenorphine/naloxone doses in hospital that day.

6. What could you prescribe to Moshe to reduce his reliance on the unregulated drug supply during his low-dose induction?

7. As Moshe is being discharged during a low-dose induction, how can you support his continuity of care?

8. Complete the Controlled Prescription Program Form for a low-dose buprenorphine/naloxone induction from Day 4 onwards. Use the guiding questions to help complete the prescription.

What strength of buprenorphine/naloxone should be prescribed?

How many days are required for a low-dose induction?

Does a low-dose induction require witnessed ingestions?

What instructions should be included in the directions for use field?

Are there any specific packaging requirements?

MAY 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

----------BC CONTROLLED PRESCRIPTION FORM----------

PERONAL HEALTH NO. | **PRESCRIBING DATE** DAY MONTH YEAR

PATIENT NAME — FIRST (GIVEN) MIDDLE INITIAL LAST (SURNAME)

PATIENT ADDRESS — CITY PROVINCE | **DATE OF BIRTH** DAY MONTH YEAR

Rx DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTIT (IN UNITS) NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE NUMERIC ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

FOLIO

PHARMACIST USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE | SIGNATURE OF DISPENSING PHARMACIST

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Case 2: Kwame

Traditional buprenorphine/naloxone induction

Kwame is a 42-year-old man admitted to hospital for the management of his asthma. He is currently not in respiratory distress and is stable on the ward.

When Kwame was admitted to hospital, he was in opioid withdrawal. Kwame has a 2-year history of opioid use disorder and would like to initiate buprenorphine/naloxone as soon as possible. He agrees to start the induction while he is in hospital. You discuss the risk of precipitated withdrawal and confirm Kwame's last use of unregulated opioids was over 24 hours ago.

Kwame's COWS score is 14. You provide 2mg/0.5mg buprenorphine/naloxone sublingual. One hour later, Kwame's withdrawal symptoms persist but have not worsened.

Name: Kwame M Taylor
Date of birth: January 3, 1981
Personal health number: 9123 456 789
Address: 123 Main Street, Victoria, BC

Case 2: Questions

1. Why is a traditional buprenorphine/naloxone induction, and not a low-dose induction, most suitable for Kwame?

2. Does Kwame require a UDT prior to initiating buprenorphine/naloxone?

3. How would you write Kwame's buprenorphine/naloxone prescription for Day 1 of the induction? (Keep in mind that he has already received an initial 2mg/0.5mg buprenorphine/naloxone SL)

4. What instructions should you provide Kwame about taking buprenorphine/naloxone?

5. What should be discussed with the nursing staff?

You see Kwame the next day and he feels better than the previous day; however, he woke up experiencing mild withdrawal symptoms this morning. His total dose on Day 1 was 16mg/3mg buprenorphine/naloxone.

6. How would you write Kwame's buprenorphine/naloxone prescription for his second day in the hospital?

You see Kwame the next day (Day 3 of his admission). His total dose the previous day was 32mg/8mg buprenorphine/naloxone. He feels much better, and is no longer experiencing cravings.

7. How would you write Kwame's buprenorphine/naloxone prescription for his third day in the hospital?

On Day 4 of Kwame's admission, he is ready to be discharged. He has already taken his buprenorphine/naloxone dose for that day in hospital.

8. What needs to be included on Kwame's discharge?

9. Complete a bridging prescription for Kwame (date June 15, 2023), assuming he has already had his buprenorphine/naloxone dose for the day and he has an appointment with a community prescriber on June 22, 2023. Use the guiding questions to help complete the prescription.

What buprenorphine/naloxone strength should be prescribed?

How long should the bridging prescription be written for?

What is Kwame's buprenorphine/naloxone dosage?

Do the buprenorphine/naloxone doses need to be witnessed?

What information should be included in the directions for use field?

JUNE 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

----------BC CONTROLLED PRESCRIPTION FORM----------

PERONAL HEALTH NO.

PRESCRIBING DATE DAY | MONTH | YEAR

PATIENT NAME — FIRST (GIVEN) | MIDDLE INITIAL | LAST (SURNAME)

PATIENT ADDRESS — CITY | PROVINCE

DATE OF BIRTH DAY | MONTH | YEAR

Rx DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM

VOID IF ALTERED

QUANTIT (IN UNITS) NUMERIC | ALPHA

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START DATE: DAY | MONTH | YEAR **END DATE:** DAY | MONTH | YEAR

TOTAL DAILY DOSE NUMERIC | ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC | ALPHA

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PRESCRIBER SIGNATURE

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Case 3: Jamiu

Continuation of methadone—split dosing

Jamiu is a 63-year-old man who presents to hospital for dyspnea, fever, and a productive cough. His diagnosis is pneumonia and he is administered intravenous antibiotics.

Jamiu initiated methadone 6 months ago for opioid use disorder treatment and is currently prescribed 120mg methadone once daily. His most recent dose increase was 2 days ago, from 110mg methadone once daily. His community pharmacy confirms that his last dose was this morning (prior to presentation at the hospital) and that he received 120mg methadone.

When you see Jamiu, he looks lethargic but rouses to voice alone. His oxygen saturation is 96% on 2L via nasal prongs. You want to continue his methadone prescription but are concerned about his respiratory status. Accordingly, you decide to split his dose into 40mg methadone three times a day and write some parameters for the nurses to follow.

Case 3: Questions

1. How should Jamiu's community methadone prescription be managed, given that he is in hospital and does not need doses dispensed from the community pharmacy?

2. What are the safety concerns associated with taking methadone during a respiratory infection? What instructions can be specified on the prescription to help moderate this risk?

3. What is the purpose of splitting Jamiu's methadone dose from 120mg once daily to 40mg three times a day?

4. When should Jamiu receive his first dose of 40mg methadone?

5. What instructions should be included on Jamiu's prescription?

Jamiu is scheduled to be discharged from hospital, after 4 days. He has finished the IV antibiotics and is given a further 6-day course of oral antibiotics to take home.

6. Given that Jamiu is on methadone, what are some considerations when deciding what oral antibiotics to prescribe?

Case 4: Valeria

Methadone initiation

Valeria is a 45-year-old woman with a 5-year history of opioid use disorder. She reports that she regularly uses unregulated opioids, including fentanyl. She is not currently receiving treatment for opioid use disorder. She presents to hospital for management of septic arthritis in her knee.

Valeria is interested in starting opioid agonist treatment, specifically methadone. She has tried buprenorphine/naloxone twice in the past. During her first induction attempt, she found the opioid withdrawal with the traditional approach uncomfortable and was unable to reach a therapeutic dose. During her second attempt, she completed a low-dose induction and was on a stable dose of 24mg/6mg buprenorphine/naloxone for 3 months. She is reluctant to try buprenorphine/naloxone again as she felt that it did not sufficiently manage her cravings.

After discussing the treatment options, Valeria would like to initiate methadone. You would like to write her methadone prescription to start today.

Name: Valeria Ngam
Date of birth: November 23, 1977
Personal health number: 9123 456 789
Address: 123 Main Street, Victoria, BC

Case 4: Questions

1. What is the recommended methadone starting dose for Valeria?

2. Why is it important to start Valeria's methadone dose conservatively and titrate up?

3. During a methadone initiation, at what rate can the dose be increased? In what circumstances may more rapid dose titrations be appropriate?

4. What should be included in the order for Valeria's first dose of methadone?

Valeria is ready to be discharged from the hospital for septic arthritis in her knee after 14 days. She is stabilized on 100mg methadone per day. The date is Friday July 7, 2023. Before discharge, Valeria receives her methadone dose for that day. She has an appointment with a community prescriber on July 14.

5. Why is it important that Valeria is on a therapeutic methadone dose at discharge?

6. Complete the Controlled Prescription Program Form for Valeria's bridging prescription. Use the guiding questions to help complete the prescription.

How long should the bridging prescription be written for?

Should the methadone doses be daily witnessed ingestion?

What information should be included in the directions for use field?

JULY 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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3	4	5	6	7	8	9
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Case 5: Kahlila

Missed methadone doses

Kahlila is a 38-year-old woman who is admitted to the hospital for a fractured ankle.

Kahlila has been on methadone for the past 5 years and has recently returned to unregulated fentanyl use and stopped taking methadone, missing her last 4 doses. Upon discussion, Kahlila shares that she would like to resume her methadone. In community, Kahlila's dose was 100mg methadone per day, daily witnessed ingestion. You call her community pharmacy, who confirm that her last witnessed dose was 5 days ago, and that she has now missed 4 consecutive days of methadone doses.

After discussion with Kahlila, you prescribe 50mg methadone once daily starting immediately.

Case 5: Questions

1. What is the purpose of decreasing Kahlila's methadone dose from 100mg to 50mg?

2. What should be included on the prescription for Kahlila's first methadone dose?

3. At what rate can Kahlila's dose be titrated up to her previous stabilization dose of 100mg methadone per day?

4. Does Kahlila's methadone dose provide pain management for her acute pain? What are the challenges of pain management in individuals on methadone?

5. How should Kahlila's acute pain from her ankle fracture be managed, both in hospital and upon discharge?

Case 6: Mackenzie

Pregnant person initiating OAT

Mackenzie is a 23-year-old non-binary person who is 3 months pregnant. They have been admitted to the hospital for severe nausea and vomiting.

They have opioid use disorder, which they were reluctant to disclose due to fear of losing custody of their child after birth. You discuss the risks associated with using unregulated opioids, including drug poisoning and adverse obstetrical concerns, such as fetal growth restriction, fetal demise, and neonatal opioid withdrawal, as well as clinical concerns regarding risk of death due to drug toxicity with using unregulated opioids. You also discuss the boundaries of your duty to report and explain that substance use during pregnancy is not grounds for reporting. You assure Mackenzie of the confidentiality of what they have disclosed. Mackenzie expresses that they would like to initiate OAT. Mackenzie shares with you that they use unregulated opioids every day and that they have not trialed any treatment in the past.

Case 6: Questions

1. How should care be approached for pregnant individuals?

2. Can OAT medications for opioid use disorder be used during pregnancy?

3. How can buprenorphine without naloxone be accessed for pregnant individuals? Why may this option be preferred over buprenorphine/naloxone?

After discussion about the treatment options, Mackenzie decides to initiate methadone

4. What are the potential benefits for pregnant individuals initiating methadone compared to untreated opioid use disorder?

5. What starting dose should be prescribed to Mackenzie? How would you write Mackenzie's initial prescription for methadone?

6. How may pregnancy alter methadone metabolism?

7. What is neonatal opioid withdrawal syndrome (NOWS) and how would you manage NOWS?

Case 7: Kenese

Initiating slow-release oral morphine

Kenese, a 63-year-old woman, is admitted into hospital after fainting. Blood tests, an ECG, and chest X-ray show that she has had a non-ST elevation myocardial infarction.

Kenese has severe opioid use disorder and is not currently receiving treatment. She regularly uses unregulated opioids, but she is currently experiencing withdrawal symptoms as she has not used any opioids since last night. Kenese tells you that she is interested in starting treatment. She has previously trialed buprenorphine/naloxone; however, she felt it did not adequately manage her cravings.

You discuss the treatment options available.

Name: Kenese R Mahelona
Date of birth: February 5, 1960
Personal health number: 9123 456 789
Address: 123 Main Street, Victoria, BC

Case 7: Questions

1. After discussing OAT options, Kenese indicates that she would like to start SROM because she will be able to reach a therapeutic dose faster than with methadone. Why may SROM most appropriate for Kenese as opposed to methadone?

2. What SROM dose should you initiate Kenese on?

3. During initiation, how often should Kenese's SROM dosage be increased and why?

4. In the past, medication shortages of SROM (brand name Kadian) have occurred. What is the usual course of action if there is a medication shortage of SROM (the 24-hour formulation)?

Kenese is ready to be discharged on May 4, 2023. She is stabilized on a daily dose of 1,100mg slow-release oral morphine and she receives her dose in hospital on the day of discharge. You help Kenese schedule an outpatient appointment with an OAT prescriber for May 10, 2023.

5. Complete a bridging prescription for Kenese using the Controlled Prescription Program form below. Use the guiding questions to help complete the prescription.

How many days should the prescription be written for?

Should SROM be prescribed as take-home doses or witnessed ingestion?

What instructions should be included in the directions for use field?

MAY 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

----------BC CONTROLLED PRESCRIPTION FORM----------

PERONAL HEALTH NO. | **PRESCRIBING DATE** DAY MONTH YEAR

PATIENT NAME — FIRST (GIVEN) MIDDLE INITIAL LAST (SURNAME)

PATIENT ADDRESS — CITY PROVINCE | **DATE OF BIRTH** DAY MONTH YEAR

Rx DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTIT (IN UNITS) NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: ____ DAY ____ MONTH ____ YEAR **END DATE:** ____ DAY ____ MONTH ____ YEAR

TOTAL DAILY DOSE NUMERIC ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

FOLIO

PHARMACIST USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE | SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES
PRINTED IN BRITISH COLUMBIA

Case 8 : Alice

Initiating buprenorphine/naloxone in the emergency department

Date: September 1, 2023

Alice, a 53-year-old woman, has arrived in the emergency department for cellulitis related to injection opioid use. She tells you that she was diagnosed with opioid use disorder 2 years ago, but she was not interested in starting OAT at that time. She shares with you that she injects opioids and occasionally snorted cocaine and that she has been experiencing more frequent drug poisonings. Alice expresses interest in initiating OAT during your conversation.

You discuss that there are treatment options available, including initiating OAT in the emergency department. You let her know that you can help locate someone to prescribe OAT in community to ensure she has a continuous OAT prescription following discharge.

Name: Alice C Rothchild
Date of birth: March 25, 1968
Personal health number: 9123 456 789
Address: 123 Main Street, Victoria, BC

Case 8: Questions

1. When may it be appropriate for a buprenorphine/naloxone induction to take place in the ED?

2. When may it be appropriate to initiate a traditional buprenorphine/naloxone induction in the ED?

3. When may it be appropriate to initiate a low-dose buprenorphine/naloxone induction in the ED?

4. Where can Alice take the first dose of a buprenorphine/naloxone induction?

5. If Alice chooses a traditional buprenorphine/naloxone induction, what medications can be administered to minimize Alice's withdrawal symptoms during the traditional buprenorphine/naloxone induction? Why should adjunct medications be administered?

After discussing buprenorphine/naloxone induction option, Alice is interested in a low-dose induction. She is concerned about experiencing significant discomfort during the moderate withdrawal required for a traditional buprenorphine/naloxone induction.

6. What other medications could you consider prescribing to Alice for a low-dose buprenorphine/naloxone induction? What information does she need before she is discharged?

Later that day, Alice is ready to be discharged from the ED. She has scheduled an appointment with a community OAT prescriber on Friday September 8, 2023. Alice has already taken her first buprenorphine/naloxone dose while in the ED. You write her a prescription to continue a home induction of buprenorphine/naloxone.

7. Complete the Controlled Prescription Program form. Use the guiding questions to help complete the prescription.

What strength of buprenorphine/naloxone should be prescribed?

How many days for daily witnessed ingestion should be specified?

What instructions should be included in the directions for use field?

Are there any specific tablet packaging requests?

When should carry doses be dispensed?

SEPTEMBER 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

----------BC CONTROLLED PRESCRIPTION FORM----------

PERONAL HEALTH NO. | **PRESCRIBING DATE** DAY MONTH YEAR

PATIENT NAME — FIRST (GIVEN) — MIDDLE INITIAL — LAST (SURNAME)

PATIENT ADDRESS — CITY — PROVINCE — **DATE OF BIRTH** DAY MONTH YEAR

Rx DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

QUANTIT (IN UNITS) NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: ____ DAY ____ MONTH ____ YEAR — **END DATE:** ____ DAY ____ MONTH ____ YEAR

TOTAL DAILY DOSE NUMERIC ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

FOLIO

PHARMACIST USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE — SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES
PRINTED IN BRITISH COLUMBIA

Safe Prescribing Agreement

By signing below, I understand that it is my responsibility to practice and prescribe in a trauma-informed and evidence-based manner, weighing the safety of the person receiving care and the public with the risks of under-treatment of opioid use disorder. To that end, I will provide structure and safety measures with my prescriptions, and engage in collaborative discussions around risks and harm reduction with people receiving care.

I am committed to seeking opportunities for ongoing learning to maintain and improve my professional knowledge and skills related to prescribing opioid agonist treatment and to monitor individuals appropriately. I am aware of existing resources, contacts, and tools that I may use to assist me in making clinical decisions related to the treatment of individuals with opioid use disorder. I will also seek out advice and assistance, when needed or required within the scope of my practice.

Following the training I have received, I will provide safe and effective treatment and monitoring for individuals with opioid use disorder. I will only practice within the scope of my training and by my professional standards of practice, as defined by my regulatory college, other guidance (e.g., decision support tools), and following the BCCSU's guidelines.

When providing education and guidance on safe prescribing practices to colleagues and learners, I will do so within the scope of my knowledge. Overall, I endeavor to improve the quality of care of opioid use disorder across our health care system.

Name, Prescriber	Signature, Prescriber	DD/MM/YYYY
_____	_____	_____
Name, Witness (Clinical Preceptor)	Signature, Witness (Clinical Preceptor)	DD/MM/YYYY
_____	_____	_____

Please print this page and send a signed version to: bccsu_education@bccsu.ubc.ca

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

Preceptorship Form

The Preceptorship Form is an online survey form to report that the preceptorship has been completed.

Complete the Preceptorship Form.

LINK: https://asdw-ext01-pub.hli.ubc.ca/ords/f?p=672:3

You will need the following to complete this form:

- College ID number
- MSP billing number
- Dates of completed preceptorship
- A copy of a government issued ID
- The POATSP online course Certificate of Completion

Once this form is completed, a notification is sent to your preceptor to complete the **Preceptor Review Evaluation**, which is required for the BCCSU to email the **Proof of Completion letter**.

Resources

Guideline for the Clinical Management of Opioid Use Disorder, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment—Breakout Resource, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Treatment of Opioid Use Disorder During Pregnancy—Guideline Supplement, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Bulletins and practice support tools, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Provincial Opioid Addiction Treatment Support Program Online Course, UBC CPD eLearning

- Available at: https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program

British Columbia Extension for Community Healthcare Outcomes (BC ECHO) on Substance Use—Opioid Use Disorder

- The BC ECHO on Substance Use is an online community of practice, consisting of a series of online webinars on evidence-based approaches to OUD care
- Offers support to health care providers in BC
- More information available at: https://bcechoonsubstanceuse.ca/

Opioid agonist treatment clinics accepting new patients

- Available at: https://www.bccsu.ca/oat-clinics-accepting-new-patients/

List of bed-based (also called residential) treatment and recovery services in BC

- Available at: https://www.bccsu.ca/recovery_services_in_bc/

Consulting addiction medicine specialists

24/7 Addiction Medicine Clinician Support Line

- Provides telephone consultation to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC
- Available to any frontline service provider working in Indigenous communities in BC
- The Support Line connects these health care providers to an addiction medicine specialist who has expertise and knowledge in addiction medicine (including emergency, acute, and community care)
- To speak to an addiction medicine specialist, call 778-945-7619
- Available 24 hours per day, 7 days per week, 365 days per year
- More information available at: https://www.bccsu.ca/24-7/

Rapid Access to Consultative Expertise (RACE) app+

- The RACE app+ allows primary care providers or specialists to rapidly connect with and receive treatment advice from a specialist, often eliminating the need for a face-to-face specialist consult or emergency department referral
- Available for physicians and nurse practitioners
- Note that this is not available for registered nurses or registered psychiatric nurses
- Available Monday to Friday (excluding statutory holidays), 8.00am–5.00pm
- Download the RACE app at:

Questions? Contact bccsu_education@bccsu.ubc.ca

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NOTES