BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Extended-release Buprenorphine Bulletin

This bulletin provides information for prescribers and pharmacists on extended-release buprenorphine, including guidance on how to prescribe, order, and dispense; and available education and training.

In December 2025, Health Canada updated the Canadian product monograph for extended-release buprenorphine to include: 1) rapid induction, 2) alternative injection sites, and 3) extended product storage. This updated bulletin reflects the recent product monograph changes. Updates are noted in green.

May 15, 2026: A clinical pearl has been added to page 7 to prevent coverage issues. Updates are noted in orange.

1.0 Overview of Extended-release Buprenorphine

Extended-release buprenorphine (brand name: Sublocade) is an extended-release formulation of buprenorphine that is administered via subcutaneous injection for the management of moderate to severe opioid use disorder.[a] Extended-release buprenorphine is fully covered as a regular benefit under PharmaCare Plans B, C, G, and Z.

a. Indivior UK Limited and Pharma Importing Inc. Product monograph: Sublocade. Toronto, ON. 2025. https://pdf.hres.ca/dpd_pm/00082639.PDF.

2.0 Evidence on Extended-release Buprenorphine

The evidence base regarding extended-release buprenorphine is limited and continues to evolve.[b]

- Extended-release buprenorphine is associated with significantly higher treatment retention (almost double; $p<0.0001$) and mean abstinence percentages (over 40%) compared to placebo (5%; $p<0.0001$) in individuals with moderate to severe opioid use disorder.[c]
- A longitudinal study of extended-release buprenorphine found that 75% of participants who were retained in extended-release buprenorphine treatment for 12 months were abstinent at 12 months compared to 24% of those who were retained in extended-release buprenorphine treatment for 0–2 months ($p<0.001$). Overall, 51% of all participants remained abstinent for 12 months.[d]
- The non-inferiority study[a] supporting extended-release buprenorphine rapid induction was conducted across multiple sites (N=729; mean age 40.7; average opioid use 15 years, mean usage 7 days/week). The study was stratified by fentanyl presence in urine screens, with 77.5% of patients presenting as fentanyl-positive at induction. Patients were randomized at a 2:1 ratio to rapid initiation, each receiving a single dose of 4mg transmucosal buprenorphine with one-hour observation, followed by extended-release buprenorphine injection. Patients in the standard induction group received daily transmucosal buprenorphine/naloxone for ≥7 days before receiving a first dose of extended-release buprenorphine. In the rapid induction arm, 66.4% of participants received a second injection, and 54.5% of the standard induction arm received a second injection. Precipitated withdrawal incidence was higher in patients positive for fentanyl (26.8%) than those negative for fentanyl (5.4%).

b. This summary is not a comprehensive review of extended-release buprenorphine.

c. Haight BR, Learned SM, Laffont CM, et al. Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: A multicentre, randomised, double-blind, placebo-controlled, phase 3 trial. Lancet. 2019; 393(10173):778-790.

d. Ling W, Vijay R, Nadipelli V, et al. Recovery from opioid use disorder (OUD) after monthly long-acting buprenorphine treatment: 12-month longitudinal outcomes from RECOVER, an observational study. J Addict Med. 2020;14(5). doi: 10.1097/ADM.0000000000000647

3.0 Information for Prescribers

- Extended-release buprenorphine is indicated for adults for the management of moderate to severe opioid use disorder
- There are two induction options for extended-release buprenorphine:
  1. A standard induction, which requires stabilization on 8mg/2mg-24mg/6mg sublingual (SL) buprenorphine/naloxone[e] for a minimum of 7 days
  2. A rapid induction (same-day start), which involves receiving an initial, single test dose[f] of sublingual buprenorphine/naloxone (e.g., 4mg[g]), followed by one hour of patient observation, to confirm tolerability[h] before administering extended-release buprenorphine
- Based on expert clinical judgement, it may be appropriate to prescribe[i] extended-release buprenorphine to clients:
  - Stabilized on 24mg/6mg–32mg/8mg SL buprenorphine/naloxone
  - Who are 18 years of age or younger
- Extended-release buprenorphine is prescribed by a physician, nurse practitioner, or an OUD-Certified Registered Nurse/Registered Psychiatric Nurse (RN/RPN(C)-OUD)[j]

e. Clients may also be inducted and stabilized on transmucosal buprenorphine; however, individuals who receive opioid agonist treatment in BC generally receive sublingual buprenorphine/naloxone as treatment unless the naloxone component is contraindicated.

f. A test dose is required to identify and reduce the risk of precipitated withdrawal with extended-release buprenorphine. Administering a test dose is a risk mitigation strategy to help reduce uncertainty with sustained precipitated withdrawal that may occur with extended-release buprenorphine.

g. 4mg reflects the example test dose noted in the product monograph. Clinical discretion based on individual patient assessment may warrant an alternative test dose. Clinicians are encouraged to call the 24/7 Addiction Medicine Clinician Support Line for decision-making support when determining an appropriate test dose.

h. Tolerability can be assessed by clinical observation and patient report of any symptoms that signal precipitated withdrawal. Clinical observation may include using the COWS to help confirm tolerability. For example, administering a SL test dose when COWS score indicates mild to moderate withdrawal (≥8), and applying COWS again after the 1-hour observation to confirm no indication of precipitated withdrawal (i.e., the absence of a significantly elevated COWS score).

i. Prescribing in these circumstances is outside of the indication specified in the product monograph. Prescribers should document the rationale for prescribing in these circumstances.

j. OUD-Certified RNs/RPNs should refer to the Decision Support Tool for Registered Nurse/Registered Psychiatric Nurse Opioid Use Disorder Certified Prescribing of Buprenorphine for detailed information on the activities that are within scope for OUD-Certified RNs/RPNs when prescribing extended-release buprenorphine.

- Consider extended-release buprenorphine if the client indicates interest or when clinical judgment determines the client could benefit significantly from extended-release buprenorphine. For example, consider for clients who:
  - Have benefitted from SL buprenorphine/naloxone but have challenges with treatment retention
  - May not be able to regularly access a pharmacy
  - Want to reduce their daily medication burden
- Treatment plan should include counselling and psychosocial supports, as determined in partnership with the client
- For a full list of contraindications, warnings, and precautions, consult the product monograph

4.0 Extended-release Buprenorphine Induction and Titration

Before initiating extended-release buprenorphine, discuss the potential benefits and risks of the medication with the client. As with initiating any treatment, prescribers should discuss potential side effects and other relevant facets of care, such as depot removal and follow-up care, with the client.

4.1 Initiating Extended-release Buprenorphine

There are two induction options for extended-release buprenorphine: standard and rapid. While the product monograph presents these as two discrete induction options, clinical experience can allow for a spectrum approach to induction, where clinical discretion may indicate a transition to extended-release buprenorphine sooner than 7 days on SL buprenorphine/naloxone. A person's induction may be slower or faster depending on their individual clinical picture. The induction approach should be selected based on clinical judgment and patient history. This may involve considering:

- Patient preferences around daily medication administration
  - e.g., inability to remember to take daily SL buprenorphine/naloxone or inability to store medication safely
- Concern around consistent access to care
  - e.g., client lives in a rural/remote setting with inconsistent transportation access, or has potential instability and may not return to care
- Drug poisoning risk or recent or frequent drug poisonings
  - i.e., frequent recent drug poisonings indicate high risk for ongoing drug poisonings, and risk may be mitigated with a rapid induction

- Risk of return to use or bridging care needs
  - e.g., client has recently been discharged from hospital and is at immediate risk of return to use
- Concern for or history of precipitated withdrawal
  - e.g., previous experience with precipitated withdrawal
- Substance use history
  - e.g., high potency opioid use like fentanyl
- Opioid agonist treatment history
  - e.g., previously stable on extended-release buprenorphine, previous dose inadequacy with SL buprenorphine/naloxone

4.1.1 Standard Induction

A standard induction requires the client to been induced and stabilized on 8mg/2mg-24mg/6mg SL buprenorphine/naloxone[k] for a minimum of 7 days. Following this, clients can be transitioned to extended-release buprenorphine.

- Prescribe **initial 300mg/1.5mL dose**
- Prescribe second dose to be administered **between 7 and 28 days after the initial dose**
  - Prescribe **300mg/1.5mL dose, except** for:
    - Clients who had been stabilized long-term on <18mg/4.5mg SL buprenorphine/naloxone prior to transitioning to extended-release buprenorphine
      - Prescribe **100mg/0.5mL dose**

k. Clients may also be inducted and stabilized on transmucosal buprenorphine; however, individuals who receive opioid agonist treatment in BC generally receive sublingual buprenorphine/naloxone as treatment unless the naloxone component is contraindicated.

4.1.2 Rapid Induction

A rapid induction allows for a same-day start of extended-release buprenorphine. For a client not on any OAT, this requires the client to have clear and objective signs of opioid withdrawal, to minimize the risk of precipitating withdrawal.

1. The client receives an initial, single test dose[l] of SL buprenorphine/naloxone (e.g., 4mg[m]) while in objective withdrawal
2. Observe the client for one hour following test dose administration, to confirm tolerability[n] (i.e., no precipitated withdrawal)
3. Administer first dose of extended-release buprenorphine (if tolerability confirmed by test dose)

There is a notable risk of precipitating withdrawal with a rapid induction, particularly in people who use fentanyl. Clinical discretion is required when considering a rapid induction.

Reported or suspected fentanyl (or other high potency opioid) use should be discussed with clients when considering the induction approach, and the risks of precipitated withdrawal with a rapid induction should be clearly detailed.

- Prescribe test dose of SL buprenorphine/naloxone (e.g., 4mg)
  - Wait one hour and observe to confirm tolerability
    - If tolerability confirmed, prescribe **initial 300mg/1.5mL dose**
- Prescribe second dose to be administered **between 7 and 28 days after the first dose**
  - Prescribe **300mg/1.5mL dose**

l. A test dose is required to identify and reduce the risk of precipitated withdrawal with extended-release buprenorphine. Administering a test dose is a risk mitigation strategy to help reduce uncertainty with sustained precipitated withdrawal that may occur with extended-release buprenorphine.

m. 4mg reflects the example test dose noted in the product monograph. Clinical discretion based on individual patient assessment may warrant an alternative test dose. Clinicians are encouraged to call the 24/7 Addiction Medicine Clinician Support Line for decision-making support when determining an appropriate test dose.

n. Tolerability can be assessed by clinical observation and patient report of any symptoms that signal precipitated withdrawal. Clinical observation may include using the COWS to help confirm tolerability. For example, administering a SL test dose when COWS score indicates mild to moderate withdrawal (≥8), and applying COWS again after the 1-hour observation to confirm no indication of precipitated withdrawal (i.e., the absence of a significantly elevated COWS score).

4.2 Dosing Schedule for Extended-release Buprenorphine Initiation

Table 1. Recommended Dosing Schedule for Extended-release Buprenorphine

	Sublingual (SL) buprenrophine/ naloxone dose prior to initation	Time between SL and extended-release (XR) buprenorphine dose	First dose of XR buprenorphine	Time between first dose of XR buprenorphine and second dose of XR buprenorphine	Second dose of XR buprenorphine	Time between second dose of XR buprenorphine and maintenance dose of XR buprenorphine	Maintenance dose of XR buprenorphine
Rapid Induction	4mg*	One hour	300mg	7–28 days**	300mg	At least 26 days	100mg or 300mg
Standard induction	8–24mg/day	7 days	300mg	7–28 days**	300mg	At least 26 days	100mg or 300mg

* 4mg is an example test dose. Clinical need may indicate an alternative test dose is appropriate.
**BC PharmaCare has updated their coverage of extended-release buprenorphine to align with the product monograph's dosing schedule.

- The recommended starting dose and second dose for extended-release buprenorphine for both induction methods is 300mg.
  - For people who have been stabilized long-term on <18mg/4.5mg SL buprenorphine/naloxone **prior** to transitioning to extended-release buprenorphine, a 100mg/0.5mL maintenance dose can be considered for dose #2 following initial 300mg induction dose.
- Patients with suspected or known use of fentanyl, or other highly potent opioid use, should be monitored after initial injection to assess for symptoms of precipitated withdrawal or sedation.
- The second dose may be administered as early as 7 days up to 28 days (~1 week to 1 month) after the initial injection, according to patient need and clinical assessment.

CLINICAL PEARL

Second doses administered between 7 and 26 days are covered by PharmaCare but require appropriate documentation to prevent coverage issues.

For prescribers: If you know you will be prescribing a second dose less than 28 days after the initial dose, indicate the day supply on the initial prescription. For example: "7-day supply." If you realize after the first prescription that the individual needs a shorter interval between their first and second doses, prescribers should indicate this on a prescription and contact their pharmacy immediately so that coverage can be reviewed.

For pharmacists: Make sure the day supply entered in PharmaCare accurately reflects the day supply written on the prescription to prevent coverage issues for the next fill. If the clinic team or prescriber requests a refill for their second dose earlier than anticipated, review documentation needed and utilize appropriate intervention codes.

4.3 Maintenance Dose

- Typical monthly maintenance dose is 100mg/0.5mL (for standard or rapid inductions); however, some individuals may require a maintenance dose of 300mg/1.5mL
  - In clinical trials with non-fentanyl-using populations, the 300mg/month maintenance dose did not provide additional efficacy as compared to the 100mg/month dose and was associated with a higher incidence of adverse events and study discontinuations.[o] However, subsequent data suggests that 300mg may lead to improved retention in populations with fentanyl use.[p,q]
- Determining a maintenance dose may require consideration of:
  - Opioid tolerance
  - Response to treatment (e.g., continuing to experience cravings or withdrawal on 100mg maintenance dose, need for supplemental SL buprenorphine)
  - Previous dosing regimen

o. Indivior UK Limited and Pharma Importing Inc. Product Monograph: Sublocade. Toronto, ON; 2025. Accessed Jan 07, 2026. https://pdf.hres.ca/dpd_pm/00082639.PDF

p. Shiwach R, Le Foll B, Alho H, Dunn KE, Strafford S, Zhao Y, Dobbins RL. Comparison of Extended-Release Buprenorphine doses for treating high-risk opioid use: A randomized clinical trial. JAMA Netw Open. 2025;8(12):e2548043. https://doi.org/10.1001/jamanetworkopen.2025.48043

q. Lee KW, Mead A, Ghauri I, Hollett B, Drolet M, Kozicky J. Initiation and dosing of Extended-Release Buprenorphine: A narrative review of emerging approaches for patients who use fentanyl. Subst Abuse Rehabil. 2025;16:71-82. https://doi.org/10.2147/SAR.S516138

4.4 Breakthrough Withdrawal

Clients may experience breakthrough cravings or withdrawal:

- During induction and titration
- Several days before their next injection
- Consistently, irrespective of treatment status

Breakthrough withdrawal may occur with extended-release buprenorphine, as plasma concentrations and mu-opioid receptor occupancy fluctuate prior to reaching a therapeutic dose. If the client is experiencing breakthrough withdrawal, clinicians should explore contributors to breakthrough withdrawal (physical versus psychologic contributors) with the client, and use shared decision-making to determine a management strategy. Management options include:

- Increase maintenance dose to 300mg/1.5mL
  - This is only an option if the person is already on a 100mg/0.5mL dose. In effect, this means that it is at least their third to fourth injection of extended-release buprenorphine.
- Continue with a 300mg/1.5mL maintenance dose (i.e., not decreasing to a 100mg maintenance dose), in the event of breakthrough withdrawal after the second dose.
- Prescribe supplemental SL buprenorphine/naloxone PRN. This can generally be up to 8mg/2mg SL buprenorphine/naloxone PRN.
  - Fewer SL buprenorphine/naloxone PRN doses may be needed after the second dose of extended-release buprenorphine
  - Some individuals may continue to need SL buprenorphine/naloxone PRN for an extended period
  - Evaluate ongoing SL buprenorphine/naloxone PRN prescription on a case-by-case basis, depending on individual needs
  - SL buprenorphine/naloxone PRN can be prescribed as take-home doses. Discuss medication management and safe storage with the client

4.5 Transitioning between Extended-Release Buprenorphine and Other Opioid Agonist Treatment

Rotation to other OAT medications is challenging. Avoid transitioning to a full agonist (i.e., methadone, SROM), if possible. Buprenorphine concentrations decrease slowly over time following the last injection, and it may take months for buprenorphine to leave a person's system completely.

Transitioning from full opioid agonists to buprenorphine-containing products is challenging in light of the risk of precipitated withdrawal. The requirement to be in moderate withdrawal before initiating buprenorphine-containing products has presented a significant challenge for individuals wanting to transition to buprenorphine. Low-dose induction on SL buprenorphine/naloxone is the preferred method for transitioning from methadone or SROM to buprenorphine-containing products, as it reduces the risk of precipitated withdrawal and does not require a wash-out period. Once stabilized on SL buprenorphine/naloxone, the patient may transition to extended-release buprenorphine via standard induction.

Clinicians are encouraged to consult the 24/7 Addiction Medicine Clinician Support Line when caring for clients wanting to transition to extended-release buprenorphine from other OAT, or from other OAT to extended-release buprenorphine.

If a shared decision is made to switch to or from extended-release buprenorphine to or from other OAT, carefully document the discussion, decision, clinical rationale, and any consultations in the person's medical record.

5.0 Arranging for Extended-release Buprenorphine Pick-up or Delivery

Given the unique dispensing pathway necessary for extended-release buprenorphine, prescribers and pharmacists should regularly communicate and create a plan for each prescription.

Before the client is transitioned to extended-release buprenorphine, the prescriber should contact the pharmacist to discuss the:

- Planned induction on to extended-release buprenorphine
- Availability of extended-release buprenorphine
- Length of time needed to have the medication ready for delivery or pick-up
- Ordering requirements from the manufacturer

For each prescription, the prescriber and pharmacist should discuss:

- The date the prescription will be dispensed
- The date of injection
- Who will administer the injection
- Pick-up or delivery
  - For pickup: Which health care provider will pick up the medication
    - Clients are not permitted to pick up the medication
  - For delivery: The delivery address
    - If the pharmacy is delivering extended-release buprenorphine, keep in mind proper storage and delivery of the medication
- Storage requirements
  - Extended-release buprenorphine must be refrigerated at between 2-8°C (35.6-46.4°F)
  - Once removed from the refrigerator, it may be stored at room temperature for up to 28 days; after which, it must be discarded
- Any additional information necessary to meet regulatory requirements

6.0 Administration

- Administer extended-release buprenorphine as a subcutaneous injection in the abdomen, thigh, buttock, or back of the upper arm
  - **Do not inject intravenously or intramuscularly**
- The selected injection site must have adequate subcutaneous tissue that does not have evidence of any skin conditions (e.g., nodules, lesions)

- Available in 2 dose strengths:
  - 100mg/0.5mL
  - 300mg/1.5mL
  - Provided in a prefilled syringe with a 19-gauge 5/8-inch (16mm) needle
- Injection must be administered by a prescriber (MD, NP, RN/RPN(C)-OUD), nurse (RN, RPN, LPN[r]), or pharmacist[s]
- Refer to the manufacturer's website, product monograph, or the Practical Administration of Sublocade Injection course for detailed instructions on administering extended-release buprenorphine

r. It is within the Scope of Practice for LPNs to administer extended-release buprenorphine with a client-specific order. Licensed Practical Nurses must meet all of the BC College of Nurses and Midwives' LPN standards, limits, and conditions and possess the individual competency to perform this activity.

s. It is within the Scope of Practice for pharmacists to administer any schedule IA, I, and II drugs by injection, including Sublocade. Pharmacists must do so within the scope of their education, training, and competence.

7.0 Pharmacy Considerations

> Pharmacists must follow the manufacturer's process to order extended-release buprenorphine and should communicate regularly with the prescriber to create a plan for dispensing each prescription.

Pharmacists are encouraged to keep up-to-date on extended-release buprenorphine education, such as through attendance of webinars hosted by the BC Pharmacy Association or the BC Centre on Substance Use.

For detailed information on storing extended-release buprenorphine, please consult the manufacturer's website.

7.1 Ordering Extended-release Buprenorphine

Indivior has launched a new registration process for pharmacies to open an account for extended-release buprenorphine.

- The requesting pharmacist must complete the online form, which includes providing the requesting pharmacist's license and the pharmacy's license
  - Indivior will review and validate the requesting pharmacist's license
  - If the pharmacist's license is not valid upon review, account set-up will be suspended
  - Indivior will notify the pharmacist and provide the opportunity to submit valid license information and complete the validation and registration process
- Indivior approves the request, and the requesting pharmacist becomes the primary pharmacist for the account at that pharmacy
- Pharmacies are advised to stock only the amount of extended-release buprenorphine needed to avoid overstocking
- More information on ordering extended-release buprenorphine can be found through the registration form

8.0 Available Training and Education

Indivior:

- Manufacturer-provided course
  - http://www.sublocadecertification.ca/
  - Prescribers are required to complete this course prior to prescribing
  - Pharmacists are strongly encouraged to complete this course prior to ordering, dispensing, or administering
- Product monograph
- Website

BCCSU and UBC Continuing Pharmacy Professional Development:

- Practical Administration of Sublocade Injection course
  - Encouraged for prescribers, nurses, and pharmacists who administer extended-release buprenorphine

BCCSU:

- Provincial Opioid Treatment Support Program
  - Module 26: Extended-release Buprenorphine (MD/NP)
  - Module 31: Extended-release Buprenorphine (RN/RPN)

9.0 Consultation

24/7 Addiction Medicine Clinician Support Line 778-945-7619

- Consult with an addiction medicine specialist 24 hours a day, 7 days a week
- Available to physicians, nurse practitioners, nurses, midwives, pharmacists, and frontline staff in Indigenous communities who are involved in substance use care in BC

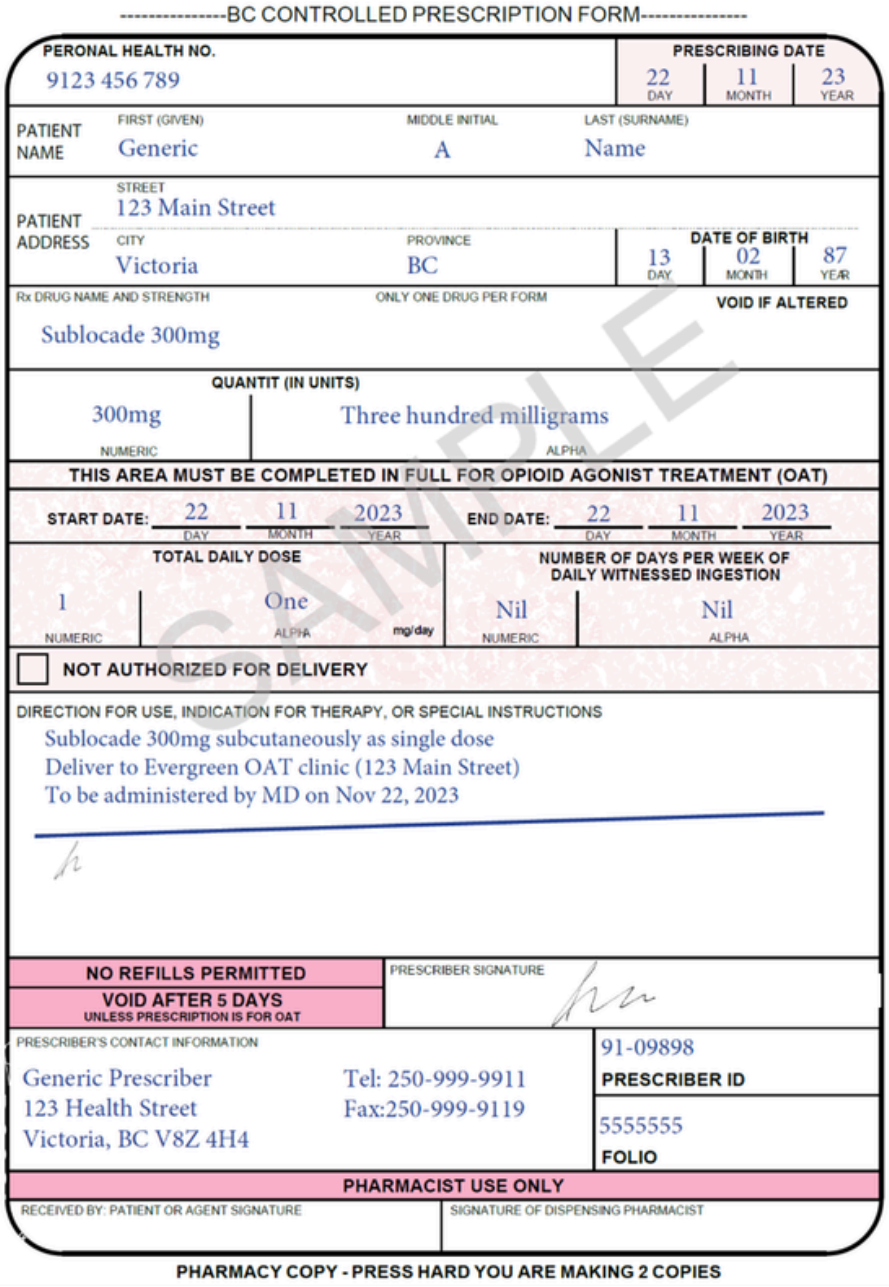
Rapid Access to Consultative Expertise (RACEapp)

- Online application where primary care providers (physicians and nurse practitioners) can receive specialist advice

Notes

- Administration of extended-release buprenorphine can be performed by an MD, NP, nurse (RN, RPN or LPN), or pharmacist
- Prescribers can consider indicating the date of administration or clinic appointment or the deliver by date on the prescription
- To avoid errors, best practice is to write "subcut" or "subcutaneously" on the prescription
- Prescription may be written as a part-fill, for example: "600mg six hundred, inject 300mg subcut once a month as a single dose by MD x 2 months (May, June), dispense 300mg in 25- to 30-day intervals."
- To avoid errors, dose reductions (i.e., reducing from 300mg/1.5mL to 100mg/0.5mL) should be written as a separate prescription, ideally after reassessment
- An example of this second prescription would be: "100mg, one hundred, inject 100mg subcut as a single dose by MD starting in July, may release 25 to 30 days after previous injection."

Example Prescription



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

PERONAL HEALTH NO.: 9123 456 789

PRESCRIBING DATE: 22 DAY | 11 MONTH | 23 YEAR

PATIENT NAME: FIRST (GIVEN) Generic | MIDDLE INITIAL A | LAST (SURNAME) Name

PATIENT ADDRESS: STREET 123 Main Street | CITY Victoria | PROVINCE BC

DATE OF BIRTH: 13 DAY | 02 MONTH | 87 YEAR

Rx DRUG NAME AND STRENGTH: Sublocade 300mg — ONLY ONE DRUG PER FORM — VOID IF ALTERED

QUANTIT (IN UNITS): 300mg NUMERIC | Three hundred milligrams ALPHA

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

START DATE: 22 DAY | 11 MONTH | 2023 YEAR — END DATE: 22 DAY | 11 MONTH | 2023 YEAR

TOTAL DAILY DOSE: 1 NUMERIC | One ALPHA mg/day

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

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS
Sublocade 300mg subcutaneously as single dose
Deliver to Evergreen OAT clinic (123 Main Street)
To be administered by MD on Nov 22, 2023

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

PRESCRIBER SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria, BC V8Z 4H4
Tel: 250-999-9911
Fax:250-999-9119

91-09898 PRESCRIBER ID

5555555 FOLIO

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SIGNATURE OF DISPENSING PHARMACIST

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SAMPLE