



**YUKON GUIDE TO THE MANAGEMENT OF OPIOID  
USE DISORDER**

May 2019



## About this Guide

This guideline draws heavily from, and references, the [BC Guideline for the Clinical Management of Opioid Use Disorder](#) (June 2017). Hereafter referred to as “BC Guideline”). In turn, these guidelines align with the [CRISM National Guideline](#) for the Clinical Management of

Opioid Use Disorder (March 2018).

It is strongly recommended that all users of this Yukon Guide have the [BC Guideline](#) on hand for reference. As we do not currently have a mechanism to check for updates, please ensure that you are using the latest version of the BC Guideline.

\*When in doubt, call the RACE line for the most current advice\*

Training in opioid dependency treatment and/or buprenorphine prescribing is strongly recommended. In addition, providers are expected to comply with Yukon Medical Council (YMC) guidelines and standards for prescribing. Consult YMC resources for further information:

[http://www.yukonmedicalcouncil.ca/pdfs/prescribing\\_buprenorphine\\_faq.pdf](http://www.yukonmedicalcouncil.ca/pdfs/prescribing_buprenorphine_faq.pdf)

## Acknowledgements

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## Feedback and Training

**We anticipate frequent changes in this Guide, and welcome feedback to improve future versions.** For inquiries and feedback, please contact Clinical and Quality Assurance Supervisor, Mental Wellness and Substance Use Services: 867-456-5519.

## BC – Yukon Opioid Agonist Treatment Community of Practice

For interest in joining a BC-Yukon Community of Practice for prescribers of Opioid Agonist Treatment, please contact Stephanie Lepsoe at [Stephanie.Lepsoe@gov.yk.ca](mailto:Stephanie.Lepsoe@gov.yk.ca).

## **Disclaimer for Health Care Providers**

The recommendations in this guideline represent the views of the BC and Yukon guideline committees, arrived at after careful consideration of the available scientific evidence and external expert peer review. When exercising clinical judgment in the treatment of opioid use disorder, health care professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of patients, their families and other service users, and in light of their duties to adhere to the fundamental principles and values of 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 Yukon Medical Council and any other relevant governing bodies. The application of the recommendations in this guideline does not override the responsibility of health care professionals to make decisions appropriate to the circumstances of an individual patient, in consultation with that patient and their guardian(s) or family members, and, when appropriate, external experts (e.g., specialty consultation). Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

## **Legal Disclaimer**

While the individuals and groups involved in the production of this document have made every effort to ensure the accuracy of the information contained in this treatment guideline, please note that the information is provided “as is” and that the BC Ministry of Health (BCMoH), the BC Centre for Substance Use (BCCSU), Yukon Health and Social Services (HSS), and Office of the Yukon Chief Medical Officer of Health (OCMOH) make no representation or warranty of any kind, either expressed or implied, as to the accuracy of the information or the fitness of the information for any particular use. To the fullest extent possible under applicable law, the BCMoH, BCCSU, HSS and OCMOH disclaims and will not be bound by any express, implied or statutory representation or warranty (including, without limitation, representations or warranties of title or non-infringement). The Guideline is intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guideline is not intended as a substitute for the advice or professional judgment of a health care professional, nor is it intended to be the only approach to the management of a clinical problem. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a health care professional.

## Abbreviations

**BCCSU** – BC Centre for Substance Use

**BCMoH** – BC Ministry of Health

**BC Guideline** - [BC Guideline for the Clinical Management of Opioid Use Disorder](#)

**COWS** – Clinical Opiate Withdrawal Scale

**DIS** – Drug Information System

**HSS** – Health and Social Services (Yukon)

**MWSUS** – Mental Wellness and Substances Use Services

**OCMOH** – Office of the Yukon Chief Medical Officer of Health

**OAT** – Opioid agonist treatment

**OD** – Opioid Use Disorder

**RACE** – Rapid Access to Consultation Expertise

**SOWS** – Subjective opiate Withdrawal Scale

**UDT** – Urine Drug Test (same as Urine Drug Screen or USD)

**WGH** – Whitehorse General Hospital

**YMC** – Yukon Medical Council



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# Patient presents with suspected opioid use disorder (OUD)

## 1. Confirm the diagnosis

The [DSM-V](#)<sup>i</sup> offers the following criteria for an OUD:<sup>ii</sup>

- (a) Opioids taken in larger amounts or over a longer period of time than intended.
- (b) Repeated unsuccessful efforts to reduce use.
- (c) Great deal of time spent obtaining or using opioids, or recovering from their effects.
- (d) Strong cravings or urges to use opioids.
- (e) Recurrent opioid use resulting in a failure to fulfill major responsibilities.
- (f) Continued use despite opioid-related social or interpersonal problems.
- (g) Reduction of major activities because of opioids (e.g., missing work, spending less time with children or spouse)
- (h) Repeatedly using opioids in situations or activities where intoxication is dangerous.
- (i) Continued use despite knowledge of opioid-related physical or psychological problems.
- (j) Tolerance (need to use more to achieve the same effect, or diminished effects with continued use of the same amount).
- (k) Withdrawal (e.g., myalgias, chills, sweating, nausea/vomiting, cramps, diarrhea, insomnia, anxiety, dysphoria).

Patients who meet two or three of these criteria have a **mild OUD**, four to five criteria indicate a **moderate OUD**, and six or more indicate a **severe OUD**.

## 2. Patient/Client assessment

- a. Assess for **alcohol and/or poly substance use** and/or poly substance withdrawal (consider cocaine, cannabis, benzodiazepines) and triage according to priority condition(s).<sup>1</sup>
- b. **Physical and mental health assessment** (including vital signs, signs of injection/substance use, general physical condition, pregnancy test, signs of opioid withdrawal, COWS score, suitability for treatment setting).
- c. **Laboratory:** Consider CBC, kidney and liver function panels; HIV and hepatitis serology, syphilis, STI screening.
- d. **Urine Drug Testing (UDT)**<sup>2</sup>  
**Rationale:** to assist in diagnosis of OUD and multi- substance use, to guide subsequent therapy through confirmation of medication compliance, to confirm stability (continued illicit drug use is not a contraindication to Buprenorphine/Naloxone (Suboxone®) therapy, however does potentially indicate instability and precludes use of take home doses).
- e. Counselling, training and dispensing of naloxone kit and other **harm reduction materials**.

## 3. Discuss treatment options with patient

Prescribers can consult the [BC RACE](#) line or local expert<sup>3</sup>. Review with patient the need for expert consultation.

Rapid Access to Consultative Expertise

Toll Free: 1-877-696-2131, Monday to Friday from 8:00 to 17:00 | [raceconnect.ca](http://raceconnect.ca)

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<sup>1</sup> Individual Clinical settings (e.g. ED, MWSUS, private clinic, etc) may need to provide additional/specific direction to guide appropriate triage, (e.g. managing alcohol withdrawal as potential life-threatening condition or managing cocaine intoxication), including determination of most appropriate setting for client/patient.

<sup>2</sup> See below for additional information on [UDT in Yukon](#).

Ordering details for UDT: SureStep 9 is available for purchase through WGH's Materials Management Dept. Contact Mat Man directly for a price quote / to order boxes. Meditech ordering number: 0027458; Mat Man Front Desk 393-8209; Patti Shaw (Purchasing) 393-8789.

<sup>3</sup> Referred Care Clinic: 210 Elliott St, Whitehorse, YT Y1A 2A2 [\(867\) 668-2552](tel:867-668-2552)

## Opioid Agonist Treatment (OAT)

Opioid agonist treatment is the first line for the management of diagnosed opioid use disorder (CRISM Guideline). “Withdrawal management strategies [clonidine etc.] alone are not effective treatment for opioid use disorder, and offering this as a standalone option to patients is neither sufficient nor appropriate.” ([BC Guideline p. 19](#) -CRISM Guideline)

Buprenorphine/Naloxone (Suboxone®) is the first line recommendation for OAT; however, the physician must discuss all management alternatives with patients, such as buprenorphine/naloxone, methadone and support through detoxification through supportive medications and/or referral to Mental Wellness and Substance Use Services (MWSUS) Withdrawal Management services (previously known as Detox).

- i. Prepare patient for Buprenorphine/Naloxone (Suboxone®) induction**
  - a. Refer to Treatment Agreement and Consent Forms ([Appendix 1](#)).
  - b. Complete Buprenorphine/Naloxone (Suboxone®) agreement ([Appendix 1](#));
  - c. Review induction plan with pharmacist. Consider pharmacy agreement ([Appendices 1c, 1d](#) <sup>4</sup>.)
  - d. Review patient’s medication list [use Drug Information System (DIS) if available].

- ii. Confirm funding source for medication coverage.**

Currently, opioid use disorder is not recognized for coverage through the Chronic Disease coverage program. However, Buprenorphine/Naloxone (Suboxone®) is currently funded through NIHB, Social Assistance, and some 3<sup>rd</sup> party companies. For individuals not funded in these ways, special coverage for both methadone and Suboxone is available through Income Support Unit, Yukon Government Health and Social Services are available. Contact: Manager of Income Support Services 867-667-5674.

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<sup>4</sup> As of December 2017, pharmacies that currently dispense OAT and are able to make arrangements for daily witnessed ingestion include both Shopper’s Drug Marts (Whitehorse); both Medicine Chests (Whitehorse); Parhelion Medical Services Pharmacy (Watson Lake). Hours and locations are [here](#).

## 4. Triage Point: Decide here on best clinical setting

In consultation with the patient and available service providers, decide on most appropriate and culturally relevant clinical setting for induction. The venue in which treatment is provided is as important as the specific medication selected. Clinicians should consider a patient's psychosocial situation, co-occurring disorders, and risk of diversion.<sup>iii</sup> Consult the facility before referring.

Possible settings:

- Opioid Treatment Services program located at the Referred Care Clinic
- Mental Wellness and Substance Use Services (MWSUS) Withdrawal Management facility (Sarah Steele Building)
- Ambulatory care (Emergency)
- Inpatient at hospital
- Outpatient via primary care clinic
- Whitehorse Correctional Centre
- Other

## 5. Start Opioid Agonist Treatment

If choosing Buprenorphine/Naloxone (Suboxone®), follow exact steps according to [Appendix 2](#) and induction algorithm / Suboxone Quick Reference - Yukon ([Appendix 3](#)).

*Ensure that follow-up plans are already in place prior to induction.*

Ensure that all steps in preparation are taken, including informed consent, ensuring that patient is in withdrawal, and that patient has access to short-term and longer term follow-up care.

If choosing methadone or other OAT, refer to appropriate specialist or care provider for induction and follow-up.

## 6. Monitoring and Follow-Up

According to the BC Guideline ([Appendix 2-Section 4 Stabilization, below](#)), establish monitoring and follow up plan with the following components:

- Ensure patient is referred for or will receive psycho-social/addiction supports <sup>iv</sup>. However, refusal of psychosocial supports need not be a barrier to accessing or starting OAT;
- Determine location for follow-up care and care provider(s);

- Ensure that Urine Drug Testing will be available (compliance, monitoring for poly substance use, safety, and assessment for diversion suspected, consult RACE/local expert);
- Pharmacy-specific supports ([Appendix 2: Induction and dosing guidelines for buprenorphine/naloxone stabilization](#) and take home dosages; [missed doses](#)<sup>5</sup>).

## APPENDICES

Please note: All forms are intended as templates; please modify as needed for your specific setting.

### Appendix 1: Opioid Agonist Treatment Agreement and Consent Forms

#### 1a. Buprenorphine/Naloxone (Suboxone®) Agreement and Consent FormV

Patient Information	
Surname: _____	Given Name(s): _____
Date of Birth: (MM/DD/Year) _____	YHIS: _____

Patient Agreement
I UNDERSTAND AND AGREE THAT:
<input type="checkbox"/> I am being started/continued on: <ul style="list-style-type: none"> <li>○ Buprenorphine/naloxone (often called Suboxone) for the treatment of opioid addiction. While I may choose to taper off this treatment at any time, I understand that most patients benefit from at least one year of treatment or longer.</li> </ul> <input type="checkbox"/> While I am receiving buprenorphine/naloxone treatment, I will only get opioid prescriptions from my buprenorphine/naloxone prescriber and will not get any from other doctors or clinics. <input type="checkbox"/> For my safety, I give consent to my buprenorphine/naloxone prescriber to communicate with my pharmacist and any other physicians involved in my case, and to check my Pharmacy Agreement (if applicable).

<sup>5</sup> For additional guidance on take home dosages, see [Appendix 5 below: Take-home Dosing Guidelines and Strategies to Reduce Diversion for Oral Agonist Therapy](#).

- I will work with my buprenorphine/naloxone prescriber to develop a treatment plan and set goals. We will review them regularly and change as needed.
- In addition to buprenorphine/naloxone, I can participate in counselling or peer-support groups and other programs, as part of my treatment plan. My buprenorphine/naloxone prescriber will give me information about the options and programs available in my community.
- I can expect confidentiality about my treatment from my doctor and other healthcare providers. My personal information will not be shared except with other healthcare providers as I agreed to above.
- I can choose my clinic and pharmacy and can decide to change either if necessary.
- I can decide if I want to continue, stop or change my treatment plan at any time. I agree to make this decision with my prescriber.
- Beginning buprenorphine/naloxone treatment may require daily trips to the pharmacy and regular visits to my prescriber, which may impact my work, school or other responsibilities.
- My prescriber may need to make changes to my treatment plan to provide the safest and best possible care. These changes might include dosage, how often I pick up my medication, how often I visit the clinic, and how often my urine is tested. Until I am stable, I will receive
- buprenorphine/naloxone through daily witnessed ingestion at a pharmacy or another healthcare provider.
- Once I am stable, my prescriber will work with me to determine if take-home doses are appropriate.
- I will not give my prescriptions or medications to anyone else.
- I will not take medication more often or at higher doses than my prescription states.
- I am the only person who may pick up my buprenorphine/naloxone prescription from the pharmacy.
- Missing more than one dose of buprenorphine/naloxone may lead to withdrawal, and missing more than 6 consecutive daily doses may cause a loss of tolerance to buprenorphine/naloxone, requiring that I take a lower dose until I stabilize.
- If I do not pick up my buprenorphine/naloxone from the pharmacy for 3 or more consecutive days, my prescription may be cancelled until my prescriber has been told the reason for my missed doses. I may receive a lower dose of buprenorphine/naloxone after multiple missed doses to prevent overdose.
- Like any prescribed medication, the pharmacy cannot replace my medication if it is lost or stolen. I cannot pick my medication up early from the pharmacy.
- I will not be cut off from treatment. If buprenorphine/naloxone is not providing the results expected, my prescriber will work with me to try other medications. If my prescriber can no longer provide care for me, they will refer me to another person who can.

I UNDERSTAND THAT I AM EXPECTED TO:

- Abstain from opioid use for 12-24 hours before I begin outpatient treatment with buprenorphine/naloxone, and that I will need to work with my doctor closely when first starting buprenorphine/naloxone. Those currently taking methadone may need to abstain longer than 72 hours.
- Provide urine for drug testing on a regular basis.
- Provide urine samples at the clinic and that these samples are not to be altered. Urine samples that are cold or appear to have been altered will be treated as a serious issue and may affect my treatment plan and ability to receive take-home doses.
- Avoid using alcohol or other drugs, such as prescription or over the counter opioid medications, sleeping pills, or tranquilizers. I understand that combining these medications with buprenorphine/naloxone can lead to overdose and other serious harms and may affect my treatment plan and ability to receive take-home doses.
- Avoid using benzodiazepines (eg: Ativan, Valium, Xanax) because of risk of oversedation.

- Notify any health care provider that I receive care from that I am taking buprenorphine/naloxone.
  - Do my best to keep appointments as scheduled. I understand that missing or skipping scheduled appointments may affect my treatment plan and ability to receive take-home doses.
  - Take my medication as prescribed. I understand that buprenorphine/naloxone contains naloxone which will cause immediate withdrawal if injected or snorted.
  - Treat others and be treated with respect. I understand that treating staff with disrespect for any reason is unacceptable and may lead to discharge from the program.
  - Keep a Narcan (naloxone) kit on hand in case of overdose and receive training in how to use it.
  - Notify my primary care provider if I become pregnant (if applicable)**
- I understand that for safety I must inform my prescriber if I am pregnant, suspect I may be pregnant, or if I am planning a pregnancy.

PATIENT IDENTIFIED GOALS:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Prescriber Agreement

I confirm that:

- This form has been reviewed in detail with the patient and they understand its content fully. This should be reviewed again when the patient is not in withdrawal.
- The patient was given time to ask questions and seek clarification before signing this document.
- The evidence for other treatment options was reviewed, and the patient agrees to buprenorphine/naloxone.
- Information and resources to support psychosocial treatment interventions and supports will be provided to the patient.
- DIS was reviewed to identify other prescribed medications, and will be checked at each subsequent appointment.
- It is my responsibility to decrease the possibility of diversion. If and when the patient is assessed as ready to receive take-home doses, guideline standards for random urine drug screens and medication checks will be pursued and clinical judgement used in an effort to limit risks of diversion.
- A treatment plan with clear goals was developed with the patient, and will be reviewed and documented regularly during treatment.

CONSENT:

Patient's  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber's  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Ib. Patient Agreement for Receiving Take-Home Dosing

In order to receive take-home doses of my medication, I, \_\_\_\_\_, agree to the following conditions to receive take-home (or “carry”) doses.

- I am aware that the accidental ingestion of even a small amount of my medication in a child or other person who is not a regular user could result in overdose or death.
- I will store my medication in a safe, locked location that cannot be accessed by other people or by pets.
- I will not sell or share my medication with another person. I understand that doing so is dangerous and may lead to loss of access to take-home doses or removal from the program.
- I will provide a urine sample within 24 hours of being asked. If I do not provide a sample as requested, or illicit drugs are found in my sample, I may lose access to take-home doses.
- I will bring my medication to my clinic or pharmacy within 24 hours if asked to do so. If I do not, I may lose access to take-home doses and have to return to daily witnessed ingestion.
- I am aware that I need to always bring my medication to my medical appointments for assessment by clinic staff. If I do not do this as requested, my carry privileges will be re-evaluated and possibly revoked.
- I understand that I must be able to meet the above requirements to receive carry doses. If my situation changes and I can no longer meet them I may lose access to take-home doses.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

If applicable, I, \_\_\_\_\_, agree to share responsibility  
(Name and relationship)

For ensuring the above person’s medication is taken as prescribed.

Witness: \_\_\_\_\_

This document was prepared with gratitude based on a template provided by Vancouver Coastal Health.

## Ic. Prescriber-Pharmacy- Patient Three Way Agreement for Methadone / Suboxone

### **Opioid Treatment Services: Prescriber-Pharmacy-Patient Three-Way Agreement for Methadone / Suboxone**

Your prescriber prescribed methadone / Suboxone maintenance treatment for your opioid dependence disorder. Our pharmacy will provide the services for methadone and Suboxone maintenance treatment.

Methadone and Suboxone are medications that are generally taken long- term and will require your commitment and responsibility to take the drug only as prescribed. A pharmacist will determine if it is safe for you to take your daily dose and then watch you as you ingest the dose. Observation of daily doses will continue until your doctor considers that you may be ready to try take-home doses. Some patients may never be considered for take-home doses if their personal safety and the safety of the community are of concern.

Your doctor or program service providers and pharmacist will work together to support you. They may consult each other, your family doctor (as applicable), or other members of your treatment team if issues and concerns arise as you progress with your treatment. You are also welcome to consult your doctor or pharmacist as needed if you have concerns about your condition or your treatment.

Your pharmacy agrees to provide you with:

- Professional, non-judgmental services that recognize your rights to respect and personal dignity.
- Access to trained professionals who are competent in methadone and Suboxone maintenance therapy to answer your questions and concerns about your treatment(s).
- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.
- Privacy and confidentiality with your private and health information. Your private information will only be shared with your consent or if we are required by law.
- Ongoing monitoring of your response and progress with methadone / Suboxone while you remain under the pharmacy's care.

Your doctor agrees to provide you with the following:

- Professional, non-judgmental, services that recognize your rights to respect and personal dignity.
- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.

This agreement is between:

\_\_\_\_\_

Your pharmacy and its staff

\_\_\_\_\_

Your prescriber

\_\_\_\_\_

You, our patient

- Regularly scheduled appointments offered at a frequency that is deemed necessary for your personal health and safety and that is based on your progress and needs while on methadone / Suboxone treatment.
- Ongoing monitoring of your response and progress with methadone while you remain in his or her care.
- Privacy and confidentiality with your private and health information. Your private information will only be shared with your consent or if required by law.

This agreement outlines responsibilities and obligations of each party to ensure a mutual understanding and awareness of the expectations involved in our collaboration. The entire agreement is detailed in the following two pages.

<p>As the patient on the methadone / Suboxone treatment, I agree to:</p> <ol style="list-style-type: none"> <li>1. Take methadone / Suboxone as treatment for my opioid dependence. I will take it as prescribed by my doctor. I will let my doctor and/or pharmacist know if I am experiencing any withdrawal effects or any side effects from the treatment.</li> <li>2. Keep my appointments with my doctor. I know that my doses of methadone /Suboxone will only be prescribed if my doctor can monitor my response and progress. I know that my appointments are especially important in the initiation phase of therapy until I am stabilized on methadone / Suboxone because the first few weeks of therapy is a time when patients can be harmed by therapy. If I do not keep my appointments, my doctor</li> </ol>	<p>As the patient on methadone /Suboxone treatment, I am aware that:</p> <ol style="list-style-type: none"> <li>1. The pharmacy will not provide me with my daily methadone / Suboxone dose if I arrive intoxicated or with other symptoms where taking the dose may be harmful to me.</li> <li>2. Methadone and Suboxone may cause drowsiness, especially at the initiation of therapy and when doses are adjusted. I agree not to drive or operate machinery that requires my alertness when I am being initiated on therapy (typically the first two weeks) or when I am having doses adjusted or if I am having treatment effects that are making me sleepy and not alert.</li> <li>3. Taking narcotics, sleeping pills, alcohol, or other sedating substances may interact with methadone and Suboxone to cause overdose, coma, or even death. I will not</li> </ol>
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<p>may no longer be able to prescribe the drug to me.</p> <ol style="list-style-type: none"> <li>3. Keep my regular daily meeting with my pharmacy to receive my daily methadone / Suboxone dose. I will make every effort to be punctual and reliable and I will call the pharmacy if I am going to be late. If I am not compliant with my daily doses, I am aware that my treatment may have to stop as it can pose a danger to me to have inconsistent dosing with my medication.</li> <li>4. Bring and show my photo ID each time I visit my pharmacy for my daily dose.</li> <li>5. The pharmacy calling my doctor they have any concerns about my safety on the treatment(s).</li> <li>6. The pharmacy calling my doctor if a dose is missed, lost, stolen, and/or partially administered.</li> <li>7. Call the local police, as well as my pharmacist and my doctor, if I lose a dose or if a dose in my possession is stolen, as the drug may be dangerous to the community.</li> <li>8. Inform any other doctor, dentist, or pharmacy that I am on methadone / Suboxone treatment. I will also inform my pharmacy and methadone /Suboxone maintenance doctor of any other medication that I am prescribed as I realize that some treatments may interact with methadone / Suboxone and cause harm to me. My methadone /Suboxone doctor may be more aware of this issue than a doctor not trained in this specialized treatment.</li> <li>9. Keep both my doctor and my doctor and pharmacist informed of all the drugs (prescription and non-prescription) that I am taking, including natural health products and vitamins.</li> </ol>	<p>take other medications unless prescribed by either my methadone / Suboxone doctor or my family doctor (if different).</p> <p>Through this agreement, I have been made aware that in Yukon, the laws that govern physicians and pharmacists require that the Triplicate Prescription Program is used to monitor methadone, Suboxone and other narcotic prescriptions. This information will be recorded. This may involve occasional review of my file by an external reviewer working within the regulatory colleges of physicians or pharmacists to view my health files or the pharmacy's prescription files. I am aware this is a legal requirement that my prescriber and pharmacist do not control that is part of the regular auditing and inspection process of their respective governing bodies. I understand that my personal health information may be shared in such circumstances as required by law.</p> <p>_____</p> <p>Patient signature</p> <p>_____</p> <p>Pharmacy representative signature</p> <p>_____</p> <p>Prescribers Signature</p> <p>_____</p> <p>Date</p>
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<p>10. Take urine tests or other tests required to monitor progress and safety of methadone / Suboxone treatments as directed by my doctor or pharmacist.</p> <p>11. Be polite and respectful while on the premise of the pharmacy. I agree that I will not be disruptive, violent, abusive or threaten or cause harm to anyone or to any property. I acknowledge that bad behaviour may result in the termination of my services from the pharmacy. Also, some offences may be brought to the attention of law enforcement as determined by territorial and federal legislation.</p>	
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This document was prepared with gratitude based on a template provided by the Referred Care Clinic

1d. Pharmacy Agreement

**Clinic name- Yukon**

{affix patient demographic label here}

Address

Telephone: Fax:

**Pharmacy Agreement**

I \_\_\_\_\_ understand that I am receiving medication from:

\_\_\_\_\_ [clinic name] – Yukon Physician **and/or**

\_\_\_\_\_ [clinic name] – Yukon Nurse Practitioner

I agree to the following conditions under which this medication is prescribed:

Only \_\_\_\_\_ (name of pharmacy) will dispense all prescription medications for me. I will not seek medications from any other drugstore.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Physician signature

This Pharmacy Agreement remains in effect from \_\_\_\_\_ until  
(date: yyyy/mm/dd)

\_\_\_\_\_  
(date: yyyy/mm/dd)

This document was prepared with gratitude based on a template provided by the Referred Care Clinic.

## Appendix 2: Induction and dosing guidelines for buprenorphine / naloxone<sup>v</sup>

### 1. General Considerations

- For new buprenorphine/naloxone prescribers, nursing and allied health professionals, completion of an online education program (e.g., [www.Suboxonecme.ca](http://www.Suboxonecme.ca)) is recommended, but not required. In addition, consultation with an addiction medicine specialist experienced in buprenorphine/naloxone prescribing is recommended, which could include accessing the provincial Rapid Access to Consultative Expertise (RACE) line service.
- Emergency department clinicians and first responders are reminded that patients with a buprenorphine/ naloxone overdose may present with typical signs and symptoms of opioid toxicity that could be less responsive to naloxone (e.g., Narcan) due to the pharmacodynamics of buprenorphine (i.e., high affinity for opioid receptors, long duration of action). Naloxone is still recommended in event of an overdose, but repeated doses (initial dose may range up to 2 mg, repeated every 2–3 minutes) or continuous intravenous administration may be required to reverse an overdose. In addition, as naloxone will be cleared more rapidly than buprenorphine, patients must continue to be monitored closely for re-emergence of overdose symptoms.

### 2. Assessment

#### Common contraindications to buprenorphine/naloxone initiation:

- Allergy to buprenorphine, naloxone, or any other components of the drug product
- Severe liver dysfunction: Careful assessment of risks and benefits of initiating treatment is advised for patients with liver enzymes > 3–5 times normal upper limit.
- Severe respiratory distress
- Delirium tremens
- Acute alcohol intoxication
- Pregnancy: The Health Canada-approved buprenorphine/naloxone product monograph no longer lists pregnancy as a contraindication to its use. Clinicians treating pregnant women or women who become pregnant with established clinical stability on buprenorphine/naloxone are advised to consult an addiction medicine specialist, the [RACE](#) line, or provincial/ territorial resources for expert guidance on management.<sup>6</sup>

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<sup>6</sup> Emergency advice 24/7 is provided through the Families in Recovery Combined Care Service, Perinatal Addictions Team through paging 604-875-2161 or contacting Jill Pascoe, Program Manager: 604-875-

## Baseline assessment

- Physical and mental health assessment
- DSM-5 confirmed diagnosis of opioid use disorder ([Appendix 4](#)).<sup>vi</sup>
- Urine drug test (positive for opioids, fentanyl, oxycodone or hydromorphone)
- Note: An opioid positive urine drug test is not a necessary prerequisite for buprenorphine/ naloxone agonist treatment. For example, an individual with a documented history of opioid use disorder who is currently abstinent from opioids but at high risk of relapse may be a good candidate for treatment.
- Laboratory tests: CBC; kidney and liver function panels; HIV and hepatitis A,B,C serology, syphilis, gonorrhea, and chlamydia serology; TB; pregnancy test (women of childbearing age)
- Liver function tests should be repeated 4 weeks after treatment initiation to check for elevated liver enzymes, particularly if patients have pre-existing hepatitis or hepatic dysfunction.
- Addiction history including assessment for other substance use disorders, including alcohol, tobacco, cocaine, and benzodiazepine use disorders
- Concurrent use of alcohol, benzodiazepines, and sedatives (i.e., CNS depressants)
- Review of Drug Information System and other requirements outlined in CPSBC Professional Standards and Guidelines for Safe Prescribing of Drugs with the Potential for Misuse/Diversion. Please refer to [www.cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf](http://www.cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf) for more information.

Clinicians are encouraged to call the Rapid Access to Consultative Expertise ([RACE](#)) line to speak with an addiction medicine specialist if any questions or concerns:

### Rapid Access to Consultative Expertise

Toll Free: 1-877-696-2131

Hours of operation are Monday to Friday, 0800-1700.

[www.raceconnect.ca](http://www.raceconnect.ca)



**RACE SERVICES FOR BC and YUKON FAMILY PHYSICIANS  
AND NURSE PRACTITIONERS**

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2828. The BCCSU [Treatment of OUD During Pregnancy Guideline Supplement](http://www.bccsu.ca/wp-content/uploads/2018/06/ODU-Pregnancy.pdf) (June 2018) is also available here: <http://www.bccsu.ca/wp-content/uploads/2018/06/ODU-Pregnancy.pdf>

### 3. Induction

Note: buprenorphine/naloxone is available as 2 mg/0.5 mg or 8 mg/2 mg sublingual tablets. Tablets can be halved and/or combined to achieve target doses described below.

#### Preparation

- a. Review risks and benefits of buprenorphine/naloxone treatment. Obtain informed consent and complete Buprenorphine/Naloxone Treatment Agreement and Consent Form ( [Appendix 1](#)).
- b. Instruct patient to discontinue opioid use 12–24 hours prior to the morning of the first day of scheduled buprenorphine/naloxone induction.
- c. Emphasize to patient that starting buprenorphine/naloxone too early (e.g., within 12–24 hours of opioid use) may worsen rather than alleviate withdrawal symptoms.
- d. Ensure patient is aware not to drive or operate heavy or hazardous machinery during induction.
- e. Emphasize that induction cannot take place during acute alcohol intoxication, and that dosing and titration may be adjusted or reduced for patients who are actively using alcohol, benzodiazepines or other sedative medications due to increased overdose risk.
- f. It is not always possible to have patients abstain from opioid use for 12-24hrs. If achieving this is unrealistic for the patient, call RACE for further induction options.
- g. For patients who have already gone through withdrawal, and therefore have a low score on the Clinical Opiate Withdrawal Scale (COWS – [Appendix 6](#)), but who are still craving opioids, start at 2mg. The rest of the induction is the same, however instead of seeing if withdrawal symptoms are resolved, see if cravings are resolved.
- h. If the patient is on methadone, call RACE for advice on how to switch from methadone to buprenorphine/naloxone<sup>7</sup>.
- i. Use COWS to assess withdrawal symptom severity.

#### Day 1

- a. Plan induction of buprenorphine/naloxone for weekday morning dosing, allowing for reassessment in the afternoon.
- b. At the time of the first dose of buprenorphine/naloxone, the risk of precipitated withdrawal is lower if the patient has signs of at least moderate opioid withdrawal. A COWS score greater than 12 at the time of induction is associated with lower risk of precipitated withdrawal. For COWS score less than 12, consider postponing first dose of buprenorphine/naloxone until later in the day or the following day, when the patient is demonstrating more severe withdrawal. For more information on clinical management of precipitated withdrawal, please refer to [Box 2](#).

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<sup>7</sup> This addition is from the Yukon Opioid and Pain Management working group clinicians.

- In general, the duration of time between last opioid dose and onset of moderate withdrawal (COWS score > 12) is as follows:

Short-acting opioids	12-16 hours since last dose	<b>Examples:</b> heroin, morphine, hydrocodone, immediate-release oxycodone
Intermediate-acting opioids	17-24 hours since last dose	<b>Examples:</b> slow-release oral morphine, controlled-release hydromorphone, sustained-release oxycodone
Long-acting opioids	30-48 hours or more since last dose	<b>Example:</b> methadone

c. The most common starting dose is two 2mg/0.5mg sublingual tablets of buprenorphine/naloxone (equivalent to total dose of 4mg/1mg buprenorphine/naloxone) when COWS >12 and no long-acting opioid has been used for at least 30 hours.

- Witnessed ingestion of the first dose is recommended, to ensure that the tablet is appropriately taken and fully dissolved sublingually.
  - Instruct patient to keep the tablet under their tongue until it dissolves, which may take up to 10 minutes, and to avoid swallowing, talking, eating, drinking, and smoking during this time.
- If there is a high risk of precipitated withdrawal (e.g., transition from long-acting opioids), or if patient is currently abstinent from opioid use, starting dose may be lowered to one 2mg/0.5mg buprenorphine/naloxone tablet.
- If the patient is experiencing severe withdrawal symptoms at the time of induction (e.g., COWS >24), starting dose may be increased to three 2mg/0.5mg buprenorphine/naloxone tablets (equivalent to total dose of 6mg/1.5mg buprenorphine/naloxone) under supervised conditions.
- Alternatively, to reduce potential for precipitated withdrawal, a buprenorphine patch (e.g., BuTrans®) can be applied the day prior to buprenorphine/naloxone induction (at least 12 hours after last methadone dose, or at least 4 hours after last short acting opioid dose). Here, specialist support or consultation is warranted, as there is limited evidence to guide this decision. In addition, Yukon Healthcare Insurance Plan and First Nations Health Benefits drug benefit plans may not provide coverage for this indication, and patients may incur out-of-pocket costs.
- For challenging inductions, referral to an inpatient withdrawal management program,

community withdrawal management team or residential treatment facility for induction can be considered.

- Under certain circumstances, and at the discretion of the treating provider, unobserved or “home” induction may be an option to consider for patients deemed appropriate, and who have a reliable caregiver in the home to monitor treatment response and contact the treating clinician in the event of a problem. It is recommended that home induction should only be offered and supervised by experienced clinicians familiar with buprenorphine/naloxone induction and treatment. General considerations for home induction are outlined below in Box 1.

#### **Box 1. General Considerations for Home or Unobserved Buprenorphine/Naloxone Inductions**

- Patients that have previous experience with buprenorphine/naloxone treatment, demonstrated reliability, a sufficiently stable home environment and ability to store medication safely may be good candidates for home induction. Patients with significant barriers to office attendance (e.g., work, school, child-care) and/or retention in care who meet the preceding criteria, or who have a caregiver that does, may also be considered.
- Patients who express significant apprehension or fear of experiencing withdrawal, or those with concurrent alcohol and sedative use or misuse, are not likely to be good candidates for home induction, unless adequate monitoring can be provided from a responsible caregiver.
- Prior to home induction, discussion of risks and benefits of home induction must be documented and informed consent secured from the patient.
- During home induction, clinicians should be willing and able to provide regular follow-up and support via telephone. All such contact should be documented in the patient’s chart. It is recommended that patients be seen in-person within 2 days of home induction. Patients with previous experience taking buprenorphine/naloxone may require less intensive support.
- Patients should be provided with clinic/office contact information, in-person education and written instructions for dosing and timing, including use of the Subjective Opioid Withdrawal Scale (SOWS – [Appendix 7](#)) to assess withdrawal symptoms and determine when to start induction (SOWS score  $\geq 17$ ), if appropriate.
- Patients and/or caregivers should be instructed to contact the office immediately in the event of any problems and be willing to come in for clinical assessment as required.

d. Since precipitated withdrawal (see [Box 2](#)) can become evident within 30 minutes of the first dose of buprenorphine/naloxone, reassess 30-60 minutes from the time of first dose.

- **If withdrawal symptoms are adequately relieved after 1-3 hours**, the induction for Day 1 is complete. Prescribe the same total dose (as administered on Day 1) for the following day.

- **If withdrawal symptoms are not adequately relieved**, administer additional dose(s). A maximum total of 12mg/3mg buprenorphine/naloxone may be administered on Day 1 depending on the individual patient's requirement. If uncertain about the need for an additional dose, consider prescribing one or two 2mg/0.5mg buprenorphine/naloxone tablets as take-home doses for withdrawal that may occur later in the evening.
- **If withdrawal symptoms are adequately relieved with additional dose(s)**, then the induction for Day 1 is complete. Prescribe the same total dose (as administered on Day 1) for the following day.
- **If withdrawal symptoms are not adequately treated with additional dose(s)**, manage withdrawal symptoms symptomatically (see step e) and continue induction the following day.

If prescribing take home tablets for day 2, prescribe their known projected Suboxone intake for day 1, for the following morning (day 2) as well. This dose should be witnessed by the pharmacist. This allows the patient to get at least a partial dose the following morning before seeing physician later that day for follow up. This decreases opioid withdrawal symptoms on day 2, and helps patient compliance with Suboxone induction.

e. In rare cases, short-term symptomatic relief may be offered by prescribing a non-opioid, non-sedative agent. For example:

- Clonidine tablets (instruct patients to take 0.1- 0.2 mg every 4 hours PRN for <12 hours)
- PRN oral anti-emetics, antidiarrheal, NSAIDs, acetaminophen can also be considered

Excerpt from the BC Guideline for the Clinical Management of Opioid Use Disorder:

### **Box 2. Management of Precipitated Withdrawal**

- Precipitated withdrawal can occur when the first dose of the partial opioid agonist buprenorphine/naloxone is administered to a patient using full agonist opioids (e.g., heroin, fentanyl, oxycodone) before they have achieved a moderate stage of opioid withdrawal. Because buprenorphine has a high affinity but low activity at the mu receptor, it rapidly displaces any full agonist opioids that are present at the receptor, which can result in a net decrease in overall opioid effects. Among patients who have used full agonist opioids recently, the sudden replacement of the full agonist opioid with buprenorphine and rapid decrease in net opioid agonist effects can precipitate significant opioid withdrawal symptoms.
- In the event that a patient develops precipitated withdrawal, clinicians may either continue or stop the induction, as outlined below.
- Both options require supportive treatment, reassurance that symptoms will resolve, and careful explanation of what has occurred to patients.
- Deciding between these two options can be guided by clinician experience, patient

preference and severity of precipitated withdrawal. For less experienced practitioners, specialty consultation (e.g., [RACE](#)) is recommended. Additional doses of buprenorphine/naloxone can result in worsening of withdrawal symptoms before improvement.

Option 1: Continue Induction (preferred)

- Explain to the patient what has occurred.
- Discuss options for management and obtain informed consent to continue with induction.
- Administer additional doses of 2mg/0.5mg buprenorphine/naloxone every 1-2 hours (up to the Day 1 maximum of 12mg/3mg buprenorphine/naloxone) until withdrawal symptoms are resolved.
- If the Day 1 maximum (12mg/3mg buprenorphine/naloxone) does not fully suppress withdrawal symptoms, offer non-opioid symptomatic treatment for withdrawal (see item e above).

Option 2: Stop Induction

- Explain to the patient what has occurred.
- Discuss options for management and obtain informed consent to stop induction.
- Provide reassurance that symptoms will resolve as opioid withdrawal runs its course.
- Offer non-opioid symptomatic treatment for withdrawal (see item e above).
- Schedule an appointment for another trial of induction on a future date, preferably the next day if possible.

## Day 2

- a. If no withdrawal symptoms present since last dose, continue a once-daily dose equal to the total amount of buprenorphine/naloxone administered on the previous day titrating up as needed in subsequent days aiming for a target dose of 16mg/4mg or greater.
  - b. If withdrawal symptoms present since last dose, administer dose equal to the total amount administered on previous day, plus an additional 4mg/1mg buprenorphine/naloxone. The maximum total dose on Day 2 should not exceed 16mg/4mg buprenorphine/naloxone.
- **If patient has already reached the maximum daily dose of 16 mg/4 mg buprenorphine/naloxone**, or if symptoms persist 2–3 hours after a second additional dose of 4 mg/1 mg buprenorphine/naloxone, manage withdrawal symptomatically for the remainder of Day 2 (refer to Day 1.e).
  - **If withdrawal symptoms are not relieved** with initial or repeated buprenorphine/naloxone doses, it is important to confirm that tablets are being taken and/or administered correctly (i.e., placing under tongue, waiting for tablet(s) to dissolve completely, no swallowing, eating, drinking, or smoking until tablet has fully dissolved).

## Day 3 Onwards

- a. On the following induction days, if withdrawal symptoms, craving, or illicit opioid use persists, continue dose increases as per the above schedule. Target dose is generally 12 mg/3 mg to 16 mg/4 mg buprenorphine/naloxone per day by the end of the first week.
- b. Titrate as needed (by 2 mg/0.5 mg to 4 mg/1 mg buprenorphine/naloxone at a time) to achieve an optimal stable dose that can sustain an entire 24-hour dosing interval with no withdrawal symptoms and no medication-related intoxication or sedation (hold buprenorphine/naloxone dose if intoxicated or sedated), up to a **maximum dose of 24 mg/6 mg buprenorphine/naloxone per day**. According to the Suboxone® product monograph, doses greater than 24 mg/6 mg daily have not been demonstrated to provide clinical advantage. Clear documentation and justification should be included in the patient record for doses that exceed 24 mg/6 mg buprenorphine/naloxone. Of note, US guidelines state that some patients may require doses up to 32 mg/8 mg buprenorphine/naloxone per day.
- c. Once optimal dose is achieved, continue to follow up once per week (or more frequently, as needed) to assess for dose effectiveness and side effects.

## 4. Stabilization

- a. Continue to assess at least every 1–2 weeks with the option to decrease follow-up visits as increasing clinical stability is achieved.
- b. Stability is defined as those who demonstrate biopsychosocial stability, such as no missed doses, abstinent from illicit drugs and have a secure place to store their medication.
- c. Follow-up assessments should include adequacy of dosage, side effects, substance use (via urine testing, when indicated), and psychosocial functioning.
- d. For clinically stable patients at stable doses, one can consider:
  - Alternate day dosing for patients who are on a stable daily dose of up to 12mg/3mg. (If transitioned to an alternate day dosing schedule, daily doses above 12mg/3mg would exceed Health Canada recommendations that the dose given on any one day should not exceed 24mg/6mg).

- For example, a patient who receives a stable daily dose of 8mg/2mg could transition to taking 16mg/4mg on alternate days.
- Gradually increasing take-home doses if stable. Always educate patients on risks to self and others when giving take-home doses. If diversion or misuse is suspected, strongly consider eliminating take-home dosing and possibly altering the dose to minimize risk of opioid toxicity once daily witnessed ingestion is resumed. Patients who continue to use illicit opioids, stimulants or alcohol are not eligible for take-home doses of medication.

e. \*When offered, take-home dosing should be increased gradually. We often have patients remain on 2-5 take home doses per week, depending on the clinical scenario. Take home doses for one week at a time are for stable patients, and take home doses for more than one week at a time occur but are reserved for very stable patients<sup>8</sup>.

Please refer to [Appendix 5 below](#): *Take-home Dosing Guidelines and Strategies to Reduce Diversion for Oral Agonist Therapy*.

## 5. Missed Doses

Due to buprenorphine’s partial agonist properties, adjusting and re-titrating a patient’s buprenorphine/naloxone dose following missed doses does not require the same degree of vigilance as methadone. However, missed doses can contribute to a loss of tolerance to buprenorphine, and dose adjustment and re-stabilization may be required if 6 or more consecutive daily doses are missed. It is recommended to schedule an appointment to assess clinical and social stability, and to check for any signs of relapse, misuse or diversion of buprenorphine/ naloxone. Reasons for missed doses should be clearly documented.

Excerpt from the BC Guideline for the Clinical Management of Opioid Use Disorder:

- For missed doses  $\leq 5$  days, resume previous dose.
- For missed doses  $\geq 6$  days, a conservative dosing guideline is:

Buprenorphine/Naloxone Dose	Number of Missed Days	Suggested Dose Adjustment (Buprenorphine/Naloxone)
2mg/0.5mg–4mg/1mg	$\geq 6$ days	No change
6mg/1.5mg–8mg/2mg	$\geq 6$ days	Restart at 4mg/1mg
> 8mg/2mg	6–7 days	Restart at 8mg/2mg
> 8mg/2mg	> 7 days	Restart at 4mg/1mg

<sup>8</sup> Additional commentary from Yukon Opioid and Pain Management working group clinicians.

- c. For missed doses with relapse or return to full agonist opioid use, advise patient to suspend use of buprenorphine/naloxone until they are ready to resume opioid agonist treatment. Schedule a new induction date and proceed as described in steps 1 and 2 above.
- d. For missed doses with an alternating day schedule, it is recommended that if a patient misses two consecutive alternating day doses, buprenorphine/naloxone should be suspended pending reassessment by a clinician. Patients should be returned to a daily dose schedule, possibly at a lowered dose, to re-stabilize prior to resuming an alternating day schedule.

## 6. Urine Drug Testing

Regular urine drug testing is the standard of care in opioid agonist programs and can be used to assess adherence to buprenorphine/naloxone treatment, validate self-reported use of opioids or other substances, detect use of other substances which may affect safety (e.g., benzodiazepines), and evaluate treatment response and outcomes (i.e., abstinence from heroin or other opioids).

Point-of-care urine drug testing is useful for providing immediate feedback to patients and for making prompt treatment decisions (e.g., prescribing take-home doses). Physicians are compensated through Fee code 0039 for performing and interpreting point-of-care urine drug testing (UDT) as part of opioid agonist treatment, up to a maximum of 26 per patient each year. Typically, point-of-care UDT can be used to detect amphetamines, benzodiazepines, THC, cocaine, opioids, oxycodone, buprenorphine, methadone and fentanyl; specific performance characteristics may vary by manufacturer.

Laboratory UDT may be used periodically to verify point-of-care UDT results, particularly if there is a discrepancy with self-reported substance use. In addition, laboratory UDT offers improved sensitivity and specificity, as well as targeted detection of specific substances, such as amphetamines (amphetamine, dextro- and methamphetamine, MDMA (Ecstasy)), benzodiazepines (diazepam, oxazepam, temazepam, triazolam), cocaine (benzoylecgonine metabolite), methadone (EDDP metabolite), and opioids (heroin metabolite, morphine, codeine, opium, and sometimes hydromorphone).

Urine drug testing for fentanyl and other synthetic opioids must be specifically requisitioned. Availability, cost and general process for requesting UDT for specific substances should be confirmed with local or hospital laboratory services. (See below [UDT in Yukon.](#))

Urine drug testing should be conducted at least monthly during induction and dose titration, until patient has reached a stable dose of buprenorphine/naloxone, or more frequently as required to confirm self-reported abstinence from illicit opioid use and/or to confirm presence of buprenorphine when patients wish to pursue take-home dosing. More frequent urine drug tests are not necessarily

required if ongoing substance use is fully disclosed by the patient. It is recommended that patients receiving take-home doses should have at least four random UDTs per year to confirm presence of buprenorphine, or more frequent as required if there are safety concerns (e.g., relapse, diversion). Please refer to **Error! Reference source not found.** for more detailed information.

#### *UDT in Yukon*

SureStep 9 is the recommended UDT for all clinics in Yukon to help ensure consistent practice across the territory<sup>9</sup>. As of February 4, 2019 all Yukon hospitals are using SureStep9 with an available single test strip for methamphetamine if requested by the physician. Note: These tests do not test for TCA.

If there is clinical doubt as to the accuracy of the SureStep 9 results, send the specimen to the Laboratory for confirmation testing. Requisition should read “Urine Drug Screen for Mass. Spec. Confirmation” and should be on a green *Referred Out* requisition. Under “Other Testing” type in “Send urine to BCCDC for mass spec” then specify for which substances you would like tested.

## 7. Rapid Induction

[Excerpt from the [BC Guideline for the Clinical Management of Opioid Use Disorder](#)]

The induction schedules provided above are based on the most up-to-date Suboxone® product monograph approved by Health Canada. However, it is important to note that with increasing clinical and research experience, there is increasing evidence that buprenorphine/naloxone induction protocols that utilize a higher dose trajectory with shorter latency to achieving a stable maintenance dose (i.e., a dose that adequately controls withdrawal symptoms for 24 hours’ duration) are associated with improved treatment outcomes, as evidenced by a recent analysis of the NIDA-funded START trial (n=740). The START protocol allowed a flexible approach to dosing, with minimal instructions to study clinicians (e.g., maximum upper limit of 16 mg/4mg buprenorphine/naloxone on Day 1, and 32 mg/8mg buprenorphine/naloxone on Days 2–168). Other than recommending dose adjustment to address participant symptoms, dose escalation rates were not explicitly outlined in the START protocol, and study clinicians employed a range of induction trajectories. The analysis explored higher versus lower dose trajectories during the first three days of induction and latency to achieve a stable dose.

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<sup>9</sup> In the fall of 2018, Yukon HSS and CMOH undertook a trial to determine which UDT would be most appropriate to use in clinical settings across Yukon. SureStep 9 was the result of that trial based on considerations such as specificity, sensitivity and cost. No UDT is perfect, but this is the currently recommended UDT to help ensure consistency across all clinics in Yukon.

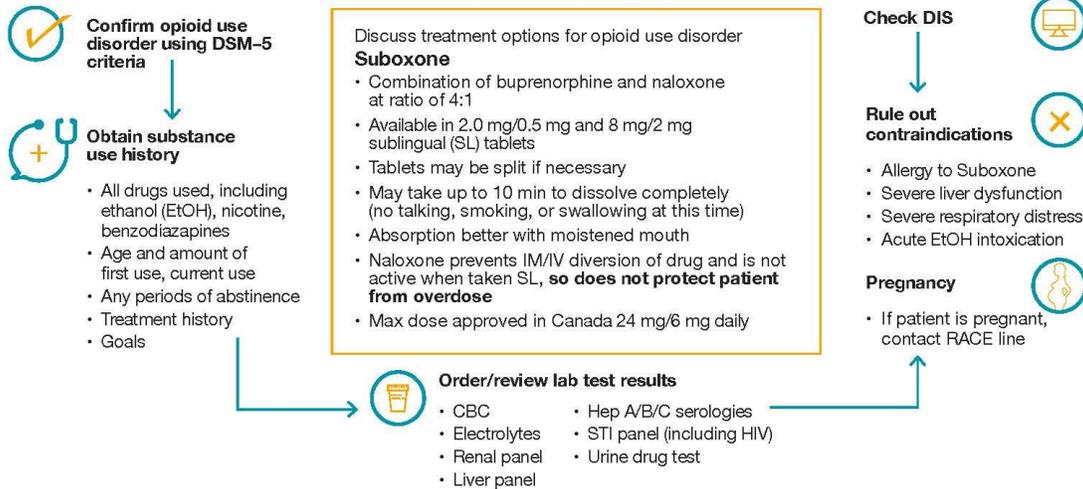
The authors found that participants who were started at a moderate dose (16 mg/4mg buprenorphine/naloxone) and shifted quickly over 3 days to a high dose (16mg/4mg-32mg/8mg buprenorphine/naloxone) were three times less likely to drop out in the first 7 days than participants who were started and maintained at a low dose (8mg/2mg-16mg/4mg buprenorphine/naloxone). Participants who were stabilized at an optimal dose quickly had less opioid use in the last 28 days of treatment than those who were slowly titrated to their optimal dose, without an increase in adverse events in the first or last 28 days of treatment. Currently, Health Canada recommends a maximum starting dose of 12mg/3mg and a maximum total dose of 24mg/6mg of buprenorphine/naloxone, however, as safety and efficacy evidence continues to accumulate, dosing recommendations may be adjusted in future to optimize the balance between patient safety and treatment effectiveness.

Buprenorphine/naloxone total daily dose can reach 32mg per day with consultation from RACE Addiction Specialist.

# PRESCRIBING SUBOXONE IN THE OUTPATIENT SETTING

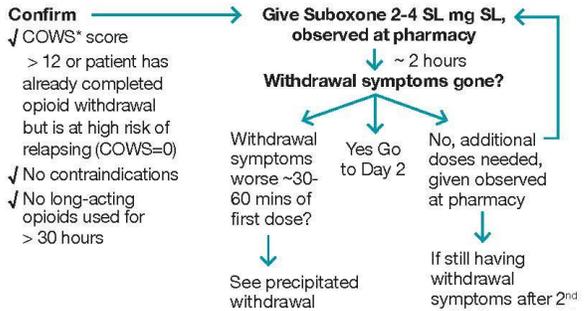
## A QUICK-REFERENCE GUIDE TO IN-OFFICE INDUCTION

### ASSESSMENT



### INDUCTION: DAY 1

- 1-2 days required for baseline assessment and initiation
- Day 1 max dose 12 mg/3 mg



**\*COWS = clinical opiate withdrawal scale**  
A validated clinical tool used to determine severity of opiate withdrawal, available free online at [www.bccsu.ca/wp-content/uploads/2017/06/BC-OD-Guidelines\\_June2017.pdf](http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OD-Guidelines_June2017.pdf) (see Appendix 6 of A Guideline for the Clinical Management of Opioid Use Disorder)

### Precipitated withdrawal

- Can occur due to replacement of full opioid receptor agonist (e.g., heroin, fentanyl, morphine) with partial agonist that binds with a higher affinity (e.g., Suboxone, methadone)
  - Occurs 30-60 min from first dose
- Symptoms**
- Similar to opiate withdrawal (i.e., increased heart rate, sweating, agitation, diarrhea, tremor, unease, restlessness, tearing, runny nose, vomiting, goose flesh)
  - Can range from mild to severe
  - Can be very distressing and discouraging for patients
  - Largely reversible with higher doses of Suboxone or other opioid
  - Avoid by ensuring adequate withdrawal before induction (COWS > 12), starting Suboxone at a lower dose (2.0 mg/0.5 mg), and reassessing more frequently
- Treatment**
- Explain what has happened
  - Provide empathetic/compassionate/apologetic support
  - Manage symptoms with clonidine, loperamide, acetaminophen and ibuprofen. Avoid benzodiazepines
  - Offer to continue with induction (see BC OUD Guidelines, page 45) or stop induction and try induction again the following day
  - Encourage/motivate patient to try again soon

## INDUCTION: DAY 2 ONWARDS

- If adequate symptom relief not achieved over Day 1 and 2, additional days (usually no more than 2) may be required
- Day 2 max dose 16 mg/4 mg

### Withdrawal symptoms recurred since last dose?

**No**

- Give Day 1 total dose again to complete induction. This will be the ongoing daily dose
- Consider titration up to optimal dose ( $\geq 12$  mg/3 mg) for improved retention in treatment
- May increase dose every 1–3 days, or less frequently

**Yes**

- Give Day 1 total plus another dose Suboxone SL 4 mg/1 mg

~ 2 hours

### Withdrawal symptoms gone?

~ 2 hours

**Yes**

- Induction complete
- Give Day 2 total as ongoing dose, or titrate up to  $\geq 12$  mg/3 mg for improved retention in treatment

**No**

- Additional doses needed
- Give Suboxone SL 4 mg/1 mg

## MAINTENANCE

Goal = once-daily dosing, no withdrawal symptoms between doses. Ideally, dose  $\geq 12$  mg/3 mg



### Monitor

- Check DIS regularly to ensure prescriptions are filled, no doctor shopping, etc.
- Follow up at least every 1-2 weeks until clinical stability is achieved
- Order urine drug testing (UDT)
- Assess for readiness for take-home dosing (“carries”), see below



### CONSIDERATIONS

#### Urine drug testing (UDT):

- Urine drug testing expected for patients on Suboxone to objectively document licit/illicit drug use
- UDT not to be used punitively but to facilitate open communication
- Perform point-of-care UDT at least monthly
- Consider ordering confirmatory testing for unexpected results (false positives do occur)



### TAKE-HOME DOSES (“CARRIES”)

- Suboxone ingestion commonly witnessed at the pharmacy but take-home doses may be prescribed
- Take-home “carries” appropriate for patients who demonstrate biopsychosocial stability, have not missed doses, are abstinent from illicit drugs, have a secure place to store their medication

## FOR ADDITIONAL SUPPORT AND RESOURCES...

**To speak to an expert in BC:** Rapid Access to Consultative Expertise (RACE) line: 1-877-696-2131

**To see the latest guidelines, research, and provincial resources:** British Columbia Centre on Substance Use: [www.bccsu.ca](http://www.bccsu.ca)

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May 2019

## Appendix 4: DSM- 5 Clinical Diagnostic Criteria for Opioid Use Disorder<sup>vii</sup>

To be eligible for methadone, buprenorphine/naloxone or slow release oral morphine agonist treatment, patients should meet DSM-5 criteria for opioid use disorder.

### DSM-5 Criteria for Opioid Use Disorder<sup>1</sup>

Clinical Diagnostic Criteria for Opioid Use Disorder (OUD)		
1	Opioids are often taken in larger amounts or over a longer period than was intended	<p>The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD)</p> <p>The severity of the OUD is defined as:</p> <p>MILD: The presence of 2 to 3 symptoms</p> <p>MODERATE: The presence of 4 to 5 symptoms</p> <p>SEVERE: The presence of 6 or more symptoms</p>
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects	
4	Craving or a strong desire to use opioids	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use	
8	Recurrent opioid use in situations in which it is physically hazardous	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	<p>Tolerance*, as defined by either of the following:</p> <ul style="list-style-type: none"> <li>a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect</li> <li>b) Markedly diminished effect with continued use of the same amount of opioid</li> </ul>	
11	<p>Withdrawal*, as manifested by either of the following:</p> <ul style="list-style-type: none"> <li>a) Characteristic opioid withdrawal syndrome</li> <li>b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms</li> </ul>	
<p>*Patients who are prescribed opioid medications for analgesia may exhibit these two criteria (withdrawal and tolerance), but would not necessarily be considered to have a substance use disorder.</p> <p><b>References:</b> American Psychiatric Association. <i>Diagnostic and statistical manual of mental disorders: DSM-5™</i>. 5th ed. Arlington, VA: American Psychiatric Publishing, Inc.</p>		

## Appendix 5: Take-home Dosing Recommendations and Strategies to Reduce Diversion for Oral Agonist Therapy

[Reference: [BC Guideline Appendix 4](#), p.53., June 2017]

Take-home dosing of oral agonist therapy may be beneficial in terms of improved motivation to participate in agonist treatment, improved treatment retention, increased patient autonomy and flexibility, positive reinforcement of abstinence, decreased treatment burden, and decreased costs related to daily witnessed ingestion. However, these benefits must be balanced against patient and public health risks associated with take-home dosing.

### 1. GENERAL CONSIDERATIONS

Due to the increased risk of overdose when opioid agonists are combined with other CNS depressants, benzodiazepines and other sedative medications should not be prescribed concurrently, and as per CSPBC guidance, DIS should be reviewed at each clinical visit to confirm that another care provider has not prescribed these medications.

Major individual and public safety differences exist between different opioid agonist therapies. For instance, an estimated 25% of prescription opioid overdose fatalities in British Columbia in recent years have involved methadone, whereas deaths resulting from buprenorphine/ naloxone are very uncommon, even in settings where rates of take-home dosing of buprenorphine/naloxone prescription are high. Hence, for buprenorphine/naloxone, take-home dosing can be considered a common part of treatment, whereas for methadone and slow-release oral morphine, treatment should involve daily witnessed ingestion, with graduated take-home dosing provided only when patient stability is clearly demonstrated and routinely assessed as described below.

### 2. BUPRENORPHINE/NALOXONE

Take-home dosing of buprenorphine-naloxone may be provided at any time at the discretion of the treating clinician, once a patient is deemed clinically stable and able to safely store medication at home (e.g., secure, locked containers or cabinets). Previous research has not demonstrated improved patient outcomes when buprenorphine/naloxone is provided via daily witnessed ingestion,<sup>3-5</sup> and there is some evidence that quick transition to take-home dosing can improve treatment adherence and retention.<sup>6,7</sup> In addition, where circumstances permit (e.g., stable housing) and no contraindications are present (e.g., sedative use) several studies have reported that unobserved home buprenorphine/naloxone inductions are comparable to office-based inductions in terms of safety, patient retention and reductions in opioid use.<sup>8-10</sup> Generally, when offered, take-home dosing is provided for **one to two weeks' worth of medication at a time**. Ideally, prescribers should include instruction to the pharmacy for take-home doses to be blister-packed (e.g., compliance packs) to

lessen the chance of diversion. Prescribers may request patients present medication packs regularly at scheduled clinic appointments or via random call-backs for pill counts.

Considerations for restricting patients to daily witnessed ingestion of buprenorphine/naloxone can include:<sup>1,11,12</sup>

- Potential for promotion of patient safety and treatment adherence via increased engagement with health care provider (i.e., physician, pharmacist) in early weeks of treatment
- Homelessness or other reasons for inability to safely store medication
- Evidence of patient diversion of medication
- Ongoing substance use, especially benzodiazepines, alcohol or other sedatives
- Length and track record of clinic attendance
- Severe behavioural issues, cognitive impairment or unstable mental health

It is the responsibility of the treating clinician to decide when take-home dosing is advisable and whether ongoing daily witnessed ingestion of buprenorphine/naloxone is optimal from a patient and public safety perspective. While Canadian guidelines and those from some other jurisdictions recommend initial daily witnessed ingestion of buprenorphine/naloxone,<sup>1,13,14</sup> U.S. guidelines are much more flexible, with recent federal amendments removing maximum take-home dose restrictions (previously restricted to a one-month take-home supply) for buprenorphine/naloxone, due to its relatively low risk for misuse and adverse events. While there are no established protocols for take-home dosing of buprenorphine/naloxone, clinicians may consider that Health Canada recommends that buprenorphine/naloxone doses should be dispensed daily under the supervision of a healthcare professional until the patient has demonstrated sufficient clinical stability and is able to safely store take-home doses. In some cases, sufficient clinical stability could be evident after buprenorphine/naloxone induction (as early as 1-3 days), in the best judgment of the treating clinician.

Consideration can also be given to providing take-home buprenorphine/naloxone doses during induction when multiple same-day visits may not be possible or practical.<sup>15,16</sup> Specifically, take-home doses may be prescribed in combination with witnessed doses, while ensuring that patients are provided with detailed instructions and telephone numbers for patient support. For example, following an initial 4mg/1mg starting dose of buprenorphine/naloxone in the clinic, a patient who is not be able to return for reassessment that same day may be given a second take-home dose of 4mg/1mg buprenorphine/naloxone to be taken in the event of recurrence of withdrawal symptoms, in order to help decrease the likelihood of illicit opiate use.

It is also important for care providers to understand that daily witnessed ingestion requirements are a common reason for patient dropout. Here, the limited risks of take-home dosing of buprenorphine/naloxone must be balanced against the risks of fatal overdose or other harms if individuals are lost from care due to daily witnessed ingestion requirements that some patients may

find unacceptable and impractical. Also, as noted above, data of improved outcomes associated with daily witnessed ingestion of buprenorphine/naloxone are lacking and some data suggest that more flexible take-home dosing improves adherence and retention.<sup>17</sup>

### **3. METHADONE**

Due to its inferior safety profile in circumstances of diversion, co-ingestion or overdose, methadone should generally be prescribed as daily-witnessed doses ingested under the supervision of a pharmacist until patients demonstrate a persistent high degree of stability including a stable dose, which typically takes months. In addition, in comparison to other treatment options, more restrictive criteria must be met prior to provision of take-home methadone doses due to these increased public safety risks. The decision to initiate take-home doses can only be made by the prescribing clinician, and rationale, including confirmation that criteria listed below have been met, must be clearly documented. Clinicians must ensure that take-home doses are safe for both patients and the public, as unsafe storage, misuse and diversion of methadone may result in lethal consequences.

Prior to provision of take-home methadone doses, the following patient criteria should be met:

- Appropriate (e.g. no evidence of cocaine, amphetamine or illicit opioid use) UDTs for a minimum of 12 weeks and established on a stable methadone dose for a minimum of 4 weeks
- Social, cognitive and emotional stability as confirmed by attending all scheduled appointments, no record of missed doses, improved social relationships or returning to work or school
- Ability to safely store methadone at home (i.e., secure, locked containers or cabinets)
- No signs of injection drug use during the 12 week monitoring phase and in follow-up.

Take-home methadone dosing schedules should start with one take-home dose per week, progressing to additional take-home doses per week slowly and at the clinician's discretion. The first dose should always be witnessed in the pharmacy on the day the prescription is picked up. Take-home doses should be dispensed in individual, appropriately sized, child-resistant containers. Containers with tamper-proof seals may also be available at some pharmacies, and should be requested if available. Most stable patients are established on a twice-weekly witnessed ingestion schedule with random medication checks as described in section 5.

### **4. SLOW-RELEASE ORAL MORPHINE (24-hour formulation)**

As there are no established protocols for slow-release oral morphine take-home dosing, it is recommended that tighter restrictions for daily witnessed ingestion be implemented, as outlined above for methadone. The standard should be indefinite daily witnessed ingestion due to the challenges in monitoring for heroin use, the diversion potential of the drug, and the potential lethality of the drug to non-tolerant individuals. In exceptional cases where patients have demonstrated high clinical stability, or when daily-witnessed dosing schedules are a significant barrier to treatment (e.g.,

employment, school, childcare), graduated take-home dosing can be considered on a case-by-case basis as per the best judgement of the treating clinician, and with appropriate monitoring and follow-up to prevent misuse or diversion.

The following should be clearly documented prior to the consideration of provision of take-home doses:

- Appropriate UDTs for a minimum of 16 consecutive weeks confirming no other drug use and established on a stable slow-release oral morphine dose for a minimum of 4 weeks
- Social, cognitive and emotional stability as confirmed by attending all scheduled appointments, no missed doses, improved social relationships
- Return to work, school or childcare that necessitates take-home doses or a significant physical disability that precludes daily visits to the pharmacy
- Ability to safely store slow-release oral morphine at home (i.e., secure, locked containers or cabinets)
- No signs of injection drug use or nasal insufflation during the 16 week monitoring phase and in follow-up. Ideal candidates for take-home doses of slow-release oral morphine have no history of injection drug use.
- No history of diversion or drug dealing (patients with this history are poor candidates for take-home doses of this medication – only with proof of extensive lifestyle change and rehabilitation should take-home doses be considered).

Take-home slow-release oral morphine schedules should start with one take-home dose per week, progressing to additional take-home doses per week every month or two months. The first slow-release oral morphine dose should always be witnessed in the pharmacy on the day the prescription is picked up. Most stable patients are established on twice-weekly witnessed ingestion. This represents a reasonable balance between safety and patient inconvenience. Ideally, prescribers should include instruction to the pharmacy for take-home doses to be blister-packed to discourage diversion and allow for better monitoring during random medication call-backs.

## **5. MONITORING OF TAKE-HOME DOSING**

Patients with take-home buprenorphine/naloxone, methadone, or slow-release oral morphine dosing privileges should be seen at least monthly to assess progress and stability. Prescribing clinicians should be vigilant in monitoring for signs of relapse to opioid use, alcohol and other (non-opioid) substance use, social instability, and diversion. For buprenorphine/naloxone, at least four unannounced urine drug tests should be performed and four unannounced pill counts should be requested during the first year, in addition to dispensed medication counts at each scheduled visit. For methadone and slow-release oral morphine, at least eight unannounced urine drug tests should be performed and four unannounced dose/pill counts should be requested during the first year, in addition to dispensed medication counts at each scheduled visit. When possible, a 24-hour phone

call protocol is suggested wherein patients are given 24-hours notice of mandatory attendance at the clinic or laboratory for urine drug tests and the clinic for random pill/dose counts.

Factors that would indicate need for follow-up and reassessment of take-home dosing privileges include:

- Self-reported or other indication of substance use, such as UDT results or evidence of injection drug use on physical exam
- Missed appointments
- Missed doses
- Requests to increase a previously stable dose
- Reports of lost, spilled, stolen or vomited doses
- Non-attendance for random urine drug testing
- Non-compliance with request for random pill counts or evidence of tampering with blister-pack.

For patients prescribed take-home buprenorphine/naloxone showing signs of major instability, individual patient circumstances should be considered when reducing the number of take-home doses of buprenorphine/naloxone, as limiting take-home dosing may result in loss to care. Following discussion with the patient about any underlying issues contributing to treatment instability, clinicians can consider reducing the number of take-home doses with return to more frequent witnessed ingestion (e.g., daily, alternating days); limiting the number of take-home doses to a single dose at a time; increasing the frequency of clinical appointments in order to provide more intensive support, monitoring and assessment; and/or providing referrals to adjunct psychosocial and community-based supports, as appropriate. If treatment intensification does not adequately address clinical or social instability, clinicians and patients can consider transitioning from buprenorphine/naloxone- to methadone-based agonist treatment. Evidence of diversion (e.g., UDT negative for buprenorphine) warrants immediate discontinuation of take-home dosing and consideration of dose reduction upon re-introduction of daily witnessed ingestion.

For patients prescribed take-home methadone showing signs of instability, prescribing clinicians should immediately reduce take-home dosing days per week and consider return to daily-witnessed ingestion if appropriate, following discussion with the patient. Clinicians should also increase the frequency of clinical appointments and provide referrals to adjunct psychosocial treatment and community-based supports. If treatment intensification and adjunct support does not address issues underlying instability, clinicians and patients can consider transitioning to an alternative agonist treatment including buprenorphine/naloxone if take-home dosing is required, or daily-witnessed slow-release oral morphine if an alternative agent is desired. Evidence of diversion (e.g., UDT

negative for methadone) warrants immediate discontinuation of take-home dosing, consideration of dose reduction upon re-introduction of DWI or of stopping methadone.

For patients prescribed take-home slow-release oral morphine showing signs of instability, prescribing clinicians should immediately reduce take-home dosing days per week and consider return to daily-witnessed ingestion, following discussion with the patient. Clinicians should also increase the frequency of clinical appointments and provide referrals to adjunct psychosocial treatment and community-based supports. Evidence of diversion (e.g., UDT negative for morphine metabolite) warrants immediate discontinuation of take-home dosing and consideration of dose reduction upon re-introduction of DWI, or, depending on circumstances, discontinuation of slow-release oral morphine treatment.

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## Appendix 6: Clinical Opiate Withdrawal Scale (COWS)



### CLINICAL OPIATE WITHDRAWAL SCALE<sup>1</sup>

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient's name: \_\_\_\_\_ Date and Time: \_\_\_\_/\_\_\_\_/\_\_\_\_:\_\_\_\_

Reason for assessment: \_\_\_\_\_

<b>Resting Pulse Rate</b> _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81–100 2 pulse rate 101–120 4 pulse rate greater than 120	<b>GI Upset over last ½ hour</b> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
<b>Sweating over past ½ hour not accounted for by room temperature or patient activity</b> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	<b>Tremor observation of outstretched hands</b> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
<b>Restlessness observation during assessment</b> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	<b>Yawning observation during assessment</b> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
<b>Pupil Size</b> 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	<b>Anxiety or Irritability</b> 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
<b>Bone or Joint Aches</b> <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	<b>Gooseflesh Skin</b> 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
<b>Runny Nose or Tearing</b> <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<p style="text-align: center;"><b>Total Score</b> _____  <i>The total score is the sum of all 11 items.</i></p> <p>Initials of person completing assessment: _____</p>

Score: 5–12 = mild; 13–24 = moderate; 25–36 = moderately severe; more than 36 = severe withdrawal

Reference:

1. Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*. 2003;35(2):253–259.

More information:  
[www.bccsu.ca](http://www.bccsu.ca)



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Reference: Clinical Opiate Withdrawal Scale [www.bccsu.ca/wp-content/uploads/2017/08/Clinical-Opiate-Withdrawal-Scale.pdf](http://www.bccsu.ca/wp-content/uploads/2017/08/Clinical-Opiate-Withdrawal-Scale.pdf)

## Appendix 7: Subjective Opiate Withdrawal Scale (SOWS)



### SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS)<sup>1</sup>

The SOWS is a self-administered scale for grading opioid withdrawal symptoms. It contains 16 symptoms whose intensity the patient rates on a scale of 0 (not at all) to 4 (extremely), and takes less than 10 minutes to complete.

Patient Instructions: please score each of the 16 items below according to how you feel right now. Circle one number only.

Item	Symptom	Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Total Score: \_\_\_\_\_

**Reference:**

- Handelsman L, Cochrane KJ, Aronson MJ, Ness R, Rubinstein KJ, Kanof PD. Two New Rating Scales for Opiate Withdrawal. 1987; American Journal of Alcohol Abuse 13, 293-308.

More information:  
[www.bccsu.ca](http://www.bccsu.ca)



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## 7. References/Resources

1. British Columbia Centre on Substance Use and B.C. Ministry of Health. *A Guideline for the Clinical Management of Opioid Use Disorder*. Published June 5, 2017.  
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2. Canadian Research Initiative on Substance Misuse. *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*. Published March 5, 2018.  
Available at:  
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3. Opioid Resources for Health Professionals: prior to July 2019:  
<http://www.hss.gov.yk.ca/opioid.php>; after July 2019: yukoncmoh.ca
4. Contact to confirm funding for Opioid Agonist Therapy via Income Support if client is not already covered: Manager, Income Support Services: 867-667-5674.
5. Contact for local Yukon expert: Referred Care Clinic 210 Elliott St, Whitehorse, YT Y1A 2A2  
[\(867\) 668-2552](tel:8676682552) - Dr. Leo Elwell.
6. American Society of Addiction Medicine (ASAM) Resources

Guidelines and consensus documents:

<https://www.asam.org/resources/guidelines-and-consensus-documents>

ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use, Adopted by the ASAM Board of Directors June 1, 2015. Available at:

<https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>

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<sup>i</sup> [Appendix 4 above](#). Or see [BC Guideline for the Clinical Management of Opioid Use Disorder](#) Appendix 5 p. 58.

<sup>ii</sup> [http://www.womenscollegehospital.ca/assets/pdf/MetaPhi/2017-11-14%20PCP\\_SafeOpioidPrescribing.pdf](http://www.womenscollegehospital.ca/assets/pdf/MetaPhi/2017-11-14%20PCP_SafeOpioidPrescribing.pdf)

<sup>iii</sup> [ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use](#). pg.26 Summary of Recommendations).

<sup>iv</sup> Yukon Health and Social Services, [Mental Wellness and Substance Use Services](#)

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<sup>v</sup> BC Guideline Appendix 2 link pp.41-47: [http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines\\_June2017.pdf](http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf)

<sup>vi</sup> BC Guideline Appendix 5 [http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines\\_June2017.pdf](http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf)

<sup>vii</sup> BC Guideline p.58 [http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines\\_June2017.pdf](http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf)