Team Name: Pharmacy and Therapeutics Team Lead: Director - Pharmacy Approved by: Regional Lead – Medical Services & Chief Medical Officer	Reference Number: CLI.6010.PL.020 Program Area: Pharmacy Policy Section: General
Issue Date: December 8, 2022 Review Date: Revision Date: September 25, 2023	Subject: Opioid Agonist Therapy

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POLICY SUBJECT:
Opioid Agonist Therapy

PURPOSE:
Opioid Agonist Therapy (OAT) is an effective treatment for addiction to opioid drugs such as heroin, oxyCODONE, morphine, HYDROmorphone, fentaNYL and codeine. The therapy involves taking the long-acting opioid agonists, methadone or buprenorphine/naloxone to replace the shorter-acting opioids the person is addicted to. These medications work to prevent withdrawal and reduce cravings for opioid drugs, without causing the person to get high. OAT can help stabilize the lives of patients with opioid use disorder, and reduce the harms related to drug use.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
Pharmacy services will facilitate continuation of care for patients previously established on methadone or buprenorphine/naloxone and initiation (if the patient is in withdrawal) in accordance with provincial guidelines.

DEFINITIONS:
Carries: a dose (or multiple doses) of methadone or buprenorphine that is provided by a community pharmacy to the patient in the community setting (i.e. not in hospital). These doses are for future use and may be ingested by the patient without supervision.

Community prescriber: the prescriber who is authorized by the provincial regulatory body (i.e. College of Physicians and Surgeons of Manitoba (CPSM)) to prescribe methadone and/or buprenorphine/naloxone for patients in the community and who normally is responsible for a client's methadone or buprenorphine/naloxone needs in the community as an outpatient.

IMPORTANT POINTS TO CONSIDER:

- Methadone is an oral substitute for heroin and other opioid narcotics. It prevents withdrawal symptoms and reduces cravings. Oral methadone does not induce euphoria in stabilized patient and it blocks the euphoric response to other opioids. Methadone's long half-life allows it to be dosed once daily for OAT. Methadone may also be used for analgesia, however since the analgesic effects of methadone do not last as long as its suppression of opioid withdrawal, it typically needs to be administered every 8 hours for pain control.
  - Some patients may experience withdrawal symptoms after being switched from one methadone-containing product to another; these patients should be clinically managed and monitored regularly.
  - Dose adjustments may be necessary in some patients.
  - Withdrawal symptoms can lead to a failure to remain in treatment and subsequent problematic substance use, which can lead to serious harm.
- Methadone products are not interchangeable from a clinical perspective nor a coverage perspective. The pharmacist will notify the hospital prescriber prior to switching a client from one methadone product to another. If a patient is new to taking methadone, the pharmacist can dispense whatever generic is usually used by the pharmacy. It is good practice for the pharmacist to notify the prescriber of the generic brand that is being used.
- If the patient is already taking methadone and presents in hospital, consideration must be given to what brand the patient has been receiving, and it may be necessary in some cases to avoid changing the brand, if possible. If the patient receives a different methadone brand, the patient and prescriber must be made aware, and arrangements for monitoring and management should be in place. Early withdrawal symptoms can lead to a failure to remain in treatment and subsequent problematic substance use, which may lead to serious harm.
- Buprenorphine/naloxone is available as a sublingual tablet and is an alternative first line option to methadone for treatment of addiction. Buprenorphine/naloxone is not a substitution to methadone for OAT. Treatment of patients with buprenorphine/naloxone that have previously been established should not be delayed. Note: buprenorphine (BuTrans) is a transdermal patch that is used for treating chronic long-term pain (not to be used for the treatment of addiction).
- Patients on OAT may be admitted for addiction related problems or other medical or surgical issues, it is important that these patients receive the same standard of care as that of any other patient.

PROCEDURE:

Continuation of Care:

- Upon admission of a patient on OAT to the hospital, access DPIN/EPR to verify day and dose (and brand of methadone if applicable) last given. The patient's community pharmacy MUST be contacted to confirm the date, time and dose of the last witnessed dose and carry (if it applies) and to notify the community pharmacy of the admission.
- Carries should be returned to pharmacy for disposal.
- If the patient has missed 3 or more consecutive days of methadone, or 6 or more consecutive days of buprenorphine/naloxone, then the hospital prescriber should be notified and the dose adjusted accordingly in consultation with the patient's community methadone or buprenorphine/naloxone prescriber.
- It is possible that a patient who is receiving multiple carries as an outpatient is not consuming their entire dose each week.
- In the interest of patient safety, it may be prudent to offer these patients a dose reduction to prevent possible overdose with the witnessed dosing of their full maintenance dose.
- This should be done in a non-judgmental and non-confrontational manner.
- Alternatively, in a methadone patient only, methadone may be given in split doses on the first 2 days and held if sedation is present.
- Upon discharge, the patient's regular community pharmacy should be contacted with last witnessed dose (in mg) and time/date taken in hospital (brand of methadone if applicable) before discharge.

Hospital Prescribers:

- Prescribers with narcotic prescribing privileges practicing in a hospital setting can prescribe methadone or buprenorphine/naloxone at the same or lower dose for continuation of therapy as long as the patient is an inpatient of the hospital under their care and is currently on methadone or buprenorphine/naloxone in the community.
- For **methadone and buprenorphine/naloxone**, all dose increases, new starts or restarts are permitted in hospital if the hospital prescriber documents a discussion with the patient's approved community prescriber or an approved prescriber who is a member of the HSC Addiction Consult Team or RAAM clinic.
    - The inpatient order needs to include the phrase "as discussed with Dr [insert name of approved prescriber the increase was discussed with]".
    - If the patient receives a different methadone brand, the patient and prescriber must be made aware, and arrangements for monitoring and management should be in place.
- The patient's community OAT prescriber MUST be kept informed that the patient has been hospitalized and any methadone or buprenorphine/naloxone dose changes made by the hospital prescriber must be discussed with the community OAT prescriber.
- Cannot provide a discharge methadone or buprenorphine/naloxone prescription to the patient unless they have methadone or buprenorphine/naloxone approval from their College.
- The community prescriber/clinic and community pharmacy need to be notified as soon as possible after discharge.

- MUST coordinate with the community OAT prescriber to ensure the patient has a valid outpatient prescription for methadone or buprenorphine/naloxone.
- To prevent a possible overdose, the prescriber should communicate with the community pharmacist to verify when the patient last received his/her methadone or buprenorphine/naloxone dose in hospital.
- A licensed physician, clinical assistant (CA), physician assistant (PA), resident or fellow with an education license can, at their discretion, prescribe a "leave of absence (LOA) medication" (Patient Resident Leave of Absence Medication - CLI.6010.PL.022) to an inpatient who is temporarily leaving the hospital and is returning to the hospital.
    - Methadone or buprenorphine/naloxone should only be provided if the patient was previously receiving carries in the community and needs to meet the requirements of a carry dose in the community.
    - The community pharmacy should be notified of the LOA provided to prevent double dosing.

Pharmacy:

- Methadone or buprenorphine/naloxone must be prepared and dispensed by a pharmacist who practices at a pharmacy that is affiliated with the hospital where the patient is admitted.

Nursing:

- Add stock to Daily Controlled Medication Record (DCMR) – double signature (pharmacy/nursing)
- Prepare and administer methadone or buprenorphine/naloxone
- Methadone or buprenorphine/naloxone should NOT be left at the patient's bedside
- MUST witness ingestion of methadone or buprenorphine/naloxone when the indication is for OAT and document in the medication administration record (MAR).
- For **methadone:**
    - Maintain a sight line until the full dose is ingested to prevent diversion
    - After the patient drinks the methadone, a short conversation is required to ensure that the entire dose has been swallowed
    - Confirmation what the methadone is necessary as some patients may try to keep the methadone in their mouth until they can spit it into the container.
    - Following ingestion of the dose, the medicine cup should be rinsed with water and the patient should be observed ingesting the water.
    - Ensure that the empty cup is returned.
- For **buprenorphine/naloxone:**
    - Ensure the sublingual tablet is placed properly under the tongue.
    - Handling of the tablets should be minimized.
    - Advise patients not to swallow their saliva while the tablets are dissolving.
    - The patient may choose to split their tablets to expedite the dissolving process.
    - If multiple tablets are required for the dose, the patient may choose to place more than one tablet under the tongue at the same time.
    - If the patient is having difficulty with dissolving the tablets, recommend that he/she drink some water BEFORE administering the tablets.

- It is essential to ensure that the tablets dissolve completely under the tongue.
- Full tablet dissolution may take up to 10 minutes or longer
- Maintain a sight line on the patient throughout the administration process
- After administration, remind patient not to drink fluids for at least 5 minutes, to ensure the full dose has been absorbed.

- Refer to Opioid Agonist Therapy Policy Highlights for Nurses (CLI.6010.PL.020.SD.01)

Initiating OAT in Hospital:

- Methadone initiated or restarted in hospital must be done by a prescriber experienced in addictions and with a valid full methadone approval from his/her college.
  - In the hospital setting, methadone may be titrated at a faster rate than that used in the community if the patient has adequate levels of monitoring (usually no faster than every 5 to 7 days due to increased risk of overdose during the first 2 weeks, due to kinetics of the drug).
  - It is important to remember that the drug is accumulating in the body for five days and that opioid cross-tolerance is incomplete and unpredictable.
- For buprenorphine/naloxone, new starts or restarts are permitted in hospital if the hospital prescriber documents a discussion with the patient's approved community prescriber (as mentioned above under hospital prescribers).

Discharge from Hospital:

- Careful planning is important to facilitate seamless transition back into the community
- Before discharge, ensure that the patient can restart their OAT as an outpatient
- Communicate with the community pharmacy and community methadone or buprenorphine/naloxone prescriber to ensure that the patient has a valid prescription for their treatment as an outpatient.
- Only approved methadone or buprenorphine/naloxone prescribers may provide a methadone or buprenorphine/naloxone prescription.
- Hospitals cannot provide take-home methadone doses to facilitate discharge, as a discharge prescription needs to be arranged before discharge can occur.
- For buprenorphine/naloxone, 1 to 2 starter pack doses can be provided if discharge is unexpected or occurs after pharmacy hours and the hospital is unable to reach the community OAT prescriber.
- The community pharmacy and community OAT prescriber must be notified as soon as possible of any starter packs provided upon discharge to prevent double dosing.

Treatment of Acute Pain:

- Methadone and buprenorphine/naloxone should not be considered treatments for acute pain.
- Acute pain should be assessed and treated.
- Assessment and treatment of acute pain in OAT patients include:
  - The objective assessment of pain
  - "Drug seeking" or a genuine request for relief of real pain
  - Appropriate dose of opiate or other analgesics or adjuncts in a methadone or buprenorphine/naloxone maintained patient

- The 2 first points by a thorough and objective assessment of the presenting illness and its correlated pain as a matter of clinical judgement.
- For mild to moderate acute pain, recommend the use of NSAIDs and acetaminophen as first line therapy, prescribed in the usual dosages and frequency.
- For more acute pain, patients may be initiated on opioid analgesics (morphine, oxycodone, hydromorphone, or codeine) in doses similar to those used for other people with similar pain.
    - Preference is to select an agent that was not their drug of choice; also should try to avoid short acting opioids.
    - Monitor the patient's pain level and adjust the dosing accordingly.
    - Patients stabilized on OAT (greater than 3 months) will likely require higher doses (10 to 50%) and more frequent dosing of short acting opioids.
    - The patient should be maintained on their usual dose of methadone or buprenorphine while being treated for acute pain.
    - Notify the community methadone or buprenorphine/naloxone prescriber.
- Pentazocine, nalbuphine and buprenorphine are partial antagonists and should not be administered to patients using methadone as they will cause severe opiate withdrawal.
- Even in the setting of an acutely painful condition, the patient who has been successfully abstinent of opioids while on OAT may not want to receive opioids for their painful condition. Shared decision making regarding the use of opioids for pain control should be done. Alternative approaches to discuss may include use of acetaminophen, NSAIDs, topical agents, systemic ketamine, regional/local anesthesia when applicable, as opioid-sparing approached to analgesia.

SUPPORTING DOCUMENTS:

CLI.6010.PL.020.SD.01 Opioid Agonist Therapy Policy Highlights For Nurses

REFERENCES:

CLI.6010.PL.022 Patient Resident Leave of Absence (LOA) Medication

Principles for the Provision of Opioid Dependence Treatment by Manitoba Pharmacist. College of Pharmacists of Manitoba.

Manitoba Methadone and Buprenorphine Maintenance: Recommended Practice. College of Physicians and Surgeons of Manitoba.

Buprenorphine/naloxone Recommended Practice Manual: In-Hospital Care. The College of Physicians & Surgeons of Manitoba.