Mental Health and Addictions Program (MHAP)

Guidelines for Prescribing Opioid Agonist Therapy (OAT) in MHAP's Opioid Recovery Program (ORP)

Version 2.0 – December 2025

Developed by NSH Prescribing OAT Consensus Panel

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Acknowledgements

We respectfully recognize that we are living and working in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People. We strive to deeply understand that this land is treaty land. Mi'kma'ki is governed by the Peace and Friendship Treaties, which were signed as a shared commitment to peace, friendship, cooperation, and respect. We are all responsible for honouring the Peace and Friendship Treaties.

We acknowledge that colonialism, broken promises and repeated violation of these treaties have caused, and continue to cause, harms for Indigenous people, leaving unmistakable marks upon the Mi'kmaq People. The MHAP commits to truth and reconciliation, recognizing the impact of ongoing harms on mental wellbeing and overall health outcomes. We are working to incorporate this understanding into the treatment and care we offer to Indigenous clients, and in our relationships with First Nations Communities, through learning, growing and changing.

We also acknowledge the histories, contributions, and legacies of the African Nova Scotian people and communities who have been here for over 400 years.

We recognize that the ongoing criminalization, institutionalization, and discrimination against people who use drugs disproportionately harm Black, Indigenous and Racialized individuals and communities, and that continuous efforts are needed to dismantle colonial systems of oppression.

We thank our clients and their families who teach us invaluable lessons about the art and practice of addiction medicine. We hope this guidance document helps to reduce the harms faced by people who use drugs and for those working toward recovery.

Contributors

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We especially thank participants in the *Prescribing OAT Discussion Series*, whose keen insights, honest questions, and rich dialogue informed the development of these guidelines. This group includes physicians, nurse practitioners, pharmacists, ORP managers, team leads, clinical nurse educators, and people with lived or living experience with Opioid Use Disorder (OUD) treatment.

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Background

MHAP is working to improve access to evidence-informed care for people living with OUD across Nova Scotia (NS). As one component of this improvement process, MHAP is establishing provincial guidelines for the primary opioid agonist therapy (OAT) medications used at ORP clinics across NS.

Evidence-informed care for OUD is evolving rapidly. With the retirement of the *College of Physicians and Surgeons of Nova Scotia: Methadone Maintenance Treatment Handbook in 2017*, MHAP ORP healthcare providers who support people living with OUD did not have up to date guidance on evidence-informed treatment that was easy to access and adapted to the NS environment.

These guidelines for *Prescribing Opioid Agonist Therapy in MHAP's Opioid Recovery Program aim to* synthesize recent evidence-based practice for OUD, through local NS perspectives, to enable a consistent practical approach to treatment decision-making and care. These guidelines was developed through a rigorous process which included the review of evidence-based documents and resources. The development team included a panel of NS OAT experts (e.g. ORP managers, staff and physicians; pharmacists; community partner representatives), who participated in twelve (12) structured 90-minute virtual discussion sessions. Guideline development sessions were held between November 2023 and November 2024.

This guideline is intended to inform treatment and practice within NSH ORP settings. Evidence-based care for people living with OUD ensures that treatment is tailored to the individual needs of patients. This guideline will inform clinical decision-making in collaboration with a patient's individual needs, preferences, and values. This guideline will be reviewed and updated as evidence and practice evolve.

Introduction

Prescribing OAT Guidelines for NSH MHAP ORP

These guidelines:

- Were developed as part of NSH's *ORP Provincial Practice Project*. Grounded in evidence and emerging best practices, the project aims to improve consistent ORP practices across Nova Scotia so that clients throughout the province can expect the same level of high-quality, safe and sustainable care for OUD.
- Align with the guiding principles of the ORP provincial practice project:
    - Offer flexible, individualized, trauma-informed, and harm reducing care.
    - Take a collaborative and evidence-informed approach.
    - Value and respect all voices and co-create safe spaces.
    - Advocate and educate to eliminate stigma and discrimination.
- Are based upon the most current evidence available at time of writing and supported by practitioner expertise. A comprehensive list of resources is included at the end of this document.
- Are intended to serve as a resource to guide decision-making for providers and teams supporting the provision of OAT in MHAP's provincial ORP.
- Provide easy access to evidence-informed approaches for the clinical management OUD for NSH st staff and providers involved in the care and management of individuals, families, and communities affected by opioid use.
- Are a collection of agreed upon practice norms intended to supplement existing standards and guidelines. These Guidelines are not meant to supersede clinical experience or decision-making specific to an assessment of a client's clinical stability and circumstances. Individualized, flexible, client-centred care is paramount.
- Comprise an iterative, living document' that will evolve with the evidence. As new research and clinical experience broaden knowledge, treatment recommendations may change.

Harm Reduction Philosophy

Harm Reduction is an evidence-based, public health approach that aims to reduce the negative health, social, legal, and economic impacts of harms related to substance use, higher risk sexual activity, and homelessness. It is an approach that does not require nor promote abstinence.

Harm Reduction includes a set of practical strategies and interventions, that includes (but is not limited to) the provision of information, education, medication, and/or supplies for safer sex, drug use, or referral to community resources so that individuals may make informed decisions (NSH, 2025).

Principles of Harm Reduction

- Accepts that people use substances for many different reasons and seeks to reduce the related harms rather than ignoring or condemning them.
- Does not deny or minimize the harms or dangers associated with drug use.
- Uses a non-judgmental, non-punitive, and non-coercive approach to care—respecting the autonomy and dignity of people who use substances.

- Acknowledges how social and structural factors (e.g., class, racism, poverty, past trauma) influence individuals' experiences with substance use, affecting both their susceptibility to harm and their ability to respond.
- Recognizes the expertise of people who use drugs and ensures their involvement in the design, implementation, and evaluation of policies and programs.

Adapted from National Harm Reduction Coalition (2024).

Harm Reduction is an approach that recognizes that sometimes harm cannot be avoided or entirely prevented. In these cases, we can take steps to reduce the likelihood or seriousness of harm. Harm reduction approaches stress the importance of eliminating stigma in the care of persons who use substances or who participate in higher risk activities (NSH, 2025).

For additional information, please see the NSH Harm Reduction Policy and Clinical Practice Supports: Harm Reduction – Lib Guides.

Language Matters

The publication Overcoming Stigma Through Language: A Primer (2019), co-developed by Canadian Centre on Substance use and Addiction and Community Addictions Peer Support Association, highlights how substance use stigma impacts people with lived and living experience, as well as their families. Stigma is any attitude, belief or behaviour that discriminates against people. Stigma often emerges through harmful language that shames and diminishes individuals. This type of language can create a cycle of behaviors and attitudes that further isolate and marginalize those who use substances.

Stigmatizing language and disrespectful actions influence how individuals perceive themselves and how society at large treats them. It's essential to remember that substance use disorders (SUD) are medical conditions that require appropriate care. Shifting to more accurate language that reflects the true nature of these conditions can help garner broader support for life-saving treatments.

Some individuals internalize the stigma related to substance use, leading to feelings of shame and worthlessness. Negative attitudes from others can exacerbate and reinforce these emotions. Global studies by the World Health Organization reveal that alcohol and drug use disorders are among the most stigmatized health conditions.

Language is an evolution where preferred terms ebb and flow over time. These guidelines aim to use language related to substance use that is compassionate and respects the dignity of individuals. Further, the guidelines invite readers to consider the impact of language and be vigilant about working towards eliminating stigma in health care.

OAT Care Principles

The Canadian Research Initiative in Substance Matters (CRISM) National Guideline for Clinical Management of OUD (CRISM, 2024) recommends that the selection of a specific OAT medication is based on both evidence and an individualized approach informed by clinical judgment. Choice of OAT medication involves collaboration between patient, provider, and team to co-create the most suitable care plan. The patient's goals and preferences are respected, and the patient's past experiences with OAT medication are taken into consideration. Any existing comorbidities and prescribed medications are reviewed to avoid potential drug interactions. **Clinical judgement informs the safest medication options.**

Optimizing retention in care is a priority for all OAT providers within ORP. Individuals taking prescribed OAT medications are less likely to die of opioid poisoning or overdose than those taking unprescribed opioids (Cheema et al., 2023).

When an individual is registered as a client of the ORP, providers will work with each patient to determine which OAT medication is most appropriate for the individual based on:

- The patient's circumstances
- Goals
- Previous treatment experiences

Providers are encouraged to document their rationale for selection of OAT medication.

OAT is a longitudinal treatment and continuity of care is critical. Ongoing follow-up with ORP is a program requirement. Psychosocial aspects of care and other supports are to be offered as part of the treatment plan when initiating pharmacotherapy.

Different opioids have different QTc prolongation risk. Morphine and buprenorphine have low risk; oxycodone, fentanyl and tramadol have intermediate risk; methadone has high risk.

Avoid withdrawal management as a standalone treatment. Three OAT options may be considered

- Buprenorphine/naloxone (bup/nlx)
  - Long-acting injectable buprenorphine (LAIB) may also be an option
- Methadone
- Slow-release oral morphine (SROM)

See Appendix A **Decision Support Tool for Selecting OAT**.

Collaboration with the dispensing pharmacy is essential to support medication safety and ensure consistent communication across the care team (see Appendix L).

Due to risk of overdose from drug-to-drug interactions, care providers are encouraged to review current substance use (including alcohol and prescription medications) with patients **at every visit** and confirm with the Drug Information System (DIS), when possible. Where possible, the recommendation is that providers check DIS, or Prescription Monitoring Program (PMP), at every appointment (or at minimum every 3 months).

During local or global emergencies and disruptions, patient care is to be adapted, as needed, to ensure patients can continue to access treatment for OUD without unreasonable barriers. Adaptations may include extended dispensing frequency, increased unwitnessed/unobserved doses, reduced urine drug testing, reduced clinic appointments / virtual care, facilitating transfer of prescriptions to a new pharmacy, or engaging other health care providers to support medication management.

OAT Prescriptions

Prescriptions for OAT must be clear and complete. See Appendix B for sample prescription script. Pharmacy practitioners must be provided with or have access to the following information:

- Drug and form (i.e., tab or film)
- Dose (total daily dose)
- Duration (include total quantity in milligrams or tablets for the entire duration of prescription)
- Directions (i.e., witness / daily witnessed ingestion (DWI)) *
- Frequency (i.e., once daily)
- Dispensing schedule, including:
    - the start and end date of the prescription **
    - the number of dispensed doses per week and schedule for observed ingestion (if applicable)
    - the days of the week that require witnessed or observed ingestion (if applicable)
- Any requirement for compliance packaging.
- *A prescription for bup/nlx, written with directions for witnessed ingestion, does not require the patient to remain under supervision until the medication has dissolved. The patient may leave the pharmacy once a pharmacy team member has directly observed the self-administration of the dose, unless specifically indicated on the prescription that the “patient is to remain under observation until the medication has dissolved” or, for short, “patient stays until dissolved”.
- ** Regardless of whether there are any authorized doses remaining, a prescription cannot be dispensed after its end date. Pharmacists are required to notify the provider when prescriptions are extended beyond the end date. If a pharmacist extends a prescription past the end date, the provider will be notified without delay.

Section 1: Buprenorphine-Naloxone

Introduction

In the absence of contraindications, bup/nlx is broadly recommended as the preferred OAT option. Current evidence identifies bup/nlx as having a more favorable safety profile for most clients with OUD; however, the clinical decision to transition to, or away from, bup/nlx must be shared with clients and balanced with the risks involved given the individual's situation. Clinicians will use an individualized and stepwise approach to determine the optimal dose for each patient. For individuals who do not stabilize with bup/nlx, or prefer another type of OAT, care providers will consult with client to consider whether methadone or SROM might be more suitable.

Selecting bup/nlx as the preferred treatment approach is suitable for most individuals that

- have been diagnosed with moderate to severe OUD,
- have no contraindications,
- have received information about all the options and given their informed consent.

Benefits

- Relative to methadone and other opioids, buprenorphine has a more favorable safety profile including lower risk of overdose, especially when combined with alcohol and benzodiazepines.
- Favourable side effect profile.
- Lower risk of QTc prolongation.
- Increased flexibility with dispensing intervals.
- Shorter time to achieve therapeutic doses.
- Fewer drug-drug interactions.

For Risks, Side Effects and Adverse Reactions, Appendix A: Decision Support Tool for Selecting OAT and/or the product monograph (Indivior UK Limited, 2021).

Buprenorphine Formulations Available in Nova Scotia

- **Tablets**: Buprenorphine/naloxone 2/0.5mg, 8/2mg, 12/3mg and 16/4mg SL.
  - Tablets MUST be taken sublingually; they are not effective when swallowed due to first-pass effect.
  - Tablets can be split, if necessary, or combined to make the required / requested dose.
- **Film**: Buprenorphine/naloxone 2/0.5mg, 4/1mg, 8/2mg, and 12/3mg SL or buccal.
  - Buccal film should not be subdivided.
- **Injectable prefilled syringes:** Long-acting injectable buprenorphine 300mg/1.5ml and 100mg/0.5ml.
  - The increased volume may increase discomfort for some individuals upon administration.

Evidence suggests no significant differences in dose effects, adverse effects, or treatment outcomes between bup/nlx film and sublingual tablets. Some patients may prefer the taste or faster dissolving time of the film compared to the sublingual tablet.

Bup/nlx film and SL tablet are not bioequivalent at all doses and routes of administration. Because some strengths of bup/nlx film produces higher bioavailability compared to the same dose of the sublingual tablet, switching between the two forms could theoretically lead to inadvertent over- or under-dosing. Switching between formulations will be done only with appropriate monitoring for symptoms of over- or

under-dosing of buprenorphine. Due to greater bioavailability when dosing buccally, initial film(s) should be administered sublingually.

Consult the product monograph (Indivior UK Limited, 2021) for further information on routes of administration.

Long-Acting Injectable Buprenorphine (LAIB)

LAIB (also known as extended-release buprenorphine) – administered monthly (26-42 days between doses) via abdominal subcutaneous injection – is indicated for individuals who have been clinically stabilized on between 4mg – 24mg sublingual bup/nlx for a minimum of 1 day. Ongoing substance use will not interfere with initiating on LAIB.

Health Canada has endorsed the FDA-approved updated **rapid initiation protocol** (Indivior PLC, 2025), where LAIB can initiated after a single dose of transmucosal buprenorphine and a one-hour observation period to confirm tolerability.

Alternative Injection Sites: LAIB can now be administered subcutaneously in the abdomen, thigh, buttock, or back of the upper arm, offering patients and healthcare providers increased flexibility in treatment administration.

Discuss potential risks and benefits, obtain informed consent, and schedule regular follow-up including monitoring for cravings and withdrawal symptoms following initiation of LAIB.

Initial monthly doses of 300mg for two months, typically followed by monthly doses of 100mg. Some individuals require a maintenance dose of 300mg.

Ensure buprenorphine sustained release injection is dispensed and/or administered in accordance with the manufacturer requirements and not dispensed directly to the patient. In practice, this may look like pharmacy delivering to the clinic or staff from clinic picking up. Also, some pharmacists are trained and set up to offer injections.

You may consider discussing switching to LAIB if the patient also:

- Requires less frequent medication administration (i.e., fewer trips to pharmacy).
- Is comfortable with a subcutaneous injection.
- Does not want to administer medications sublingually.
- Has drug coverage or is able to cover the cost of medication.

When switching from LAIB back to sublingual or buccal bup/nlx, high levels of bup/nlx remain in the system for several months following discontinuation due to the extended-release properties of the formulation. For this reason, it is not recommended to resume the previous oral dose immediately. Initiate oral bup/nlx at a low staring dose, based on the timing of the last injection, patient response, and clinical presentation. Gradually titrate up as clinically indicated.

Initiating OAT with Buprenorphine-Naloxone

Precipitated Withdrawal

The unique pharmacology of bup/nlx can lead to a risk of precipitated withdrawal when initiating the medication. Precipitated withdrawal is a state of severe and acute withdrawal that can occur if the initial dose of buprenorphine is given when a client still has other opioids active on the receptor. As buprenorphine is a partial opioid agonist with high affinity, it displaces other opioids but does not fully replace their effect, leaving the patient with a net opioid deficit.

If precipitated withdrawal occurs, withdrawal symptoms will appear as early as 15 to 60 minutes after taking bup/nlx. This may discourage a patient who is new to buprenorphine from continuing with treatment, so it is imperative to take preventative and supportive measures. (See Table 1.1)

To reduce the risk of precipitated withdrawal, provide a sufficient time lapse from the last use of opioids. Traditional initiation doses of bup/nlx require the patient to be in at least moderate opioid withdrawal prior to the first dose. If the individual is unable, or prefers not, to experience withdrawal, consider micro-dosing. Apply extra caution and guidance when initiating treatment for people who are prescribed/taking methadone or who are fentanyl tolerant.

To avoid precipitated withdrawal, the Clinical Opiate Withdrawal Scale (COWS) is a tool used to assist in this determination. The timing of the last reported use of opioids can be useful in determining whether it is safe to proceed. If client is in moderate withdrawal (COWS≥12), initiation of treatment can usually be considered. (See Table 1.2).

Table 1.1: Pharmacotherapy for Symptomatic Treatment of Opioid Withdrawal

Symptoms	Medication	Dosage
Agitation, excessive sympathetic overdrive (e.g., anxiety, agitation tachycardia, and tremor)	Clonidine	0.1–0.2mg PO PRN every 4-6 hours (for <12 hours for precipitated withdrawal)
Insomnia	Trazodone	50mg PO QHS PRN
Nausea	Dimenhydrinate	50–100mg PO Q6H PRN
Pain	Acetaminophen	325–1000mg PO PRN every 4-6 hours (maximum 4000mg day; 2000mg for older adults or those with liver impairment)
	NSAIDS (e.g., Ibuprofen)	400mg PO PRN every 8 hours
Diarrhea	Loperamide	2–4mg PRN (maximum 16mg day)
Don't prescribe benzodiazepines for opioid withdrawal symptoms.		

Initiation Setting

Before commencing bup/nlx, consider the preferred setting(s) in which to initiate dosing, and strategies to reduce the risk of precipitated withdrawal. OAT providers will explore the practical advantages and disadvantages of each protocol with patients to find the best fit for them.

There are several options for initiating OAT with bup/nlx, each addressed with more information below:

1. Pharmacy or clinic start: First dose is usually administered at the pharmacy when the patient is in withdrawal; subsequent doses are taken as required on the same day, either in the same location or by the patient at home.
2. Home Initiation: Patient is given a prescription to start at home.
3. Micro-dosing: For patients who cannot stop opioids long enough to avoid precipitated withdrawal and for patients who prefer to avoid moderate withdrawal, regardless of what opioid(s) they use.
4. Macro-dosing: For patients who are fentanyl tolerant.
5. Rotating methadone to bup/nlx: Some patients who show a successful and sustained response to methadone may wish to transition to bup/nlx.

1. Pharmacy/Clinic Start

Traditional pharmacy or clinic initiation protocols require a period of abstinence from opioids prior to initiation, to prevent precipitated withdrawal. If client is opioid tolerant, willing and able to experience moderate withdrawal before initiating bup/nlx (COWS≥12) and has had adequate time since last opioid use to prevent precipitated withdrawal (see Table 1.2 below), they may be suitable for traditional pharmacy or clinic initiation.

This may not be the preferred option for patients who currently use fentanyl or other intermediate- and long-acting opioids (e.g., methadone) that require longer periods of pre-initiation withdrawal, which can be both time-consuming and difficult for patients. If client is unable, or prefers not to experience withdrawal, consider micro-dosing. Providers should discuss the risks and benefits of all initiation options with patients and support informed decision-making. See micro-dosing for more details.

Table 1.2: Clinical Opiate Withdrawal Scale (COWS)

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 Hours	*Examples*: Heroin, morphine, hydrocodone, immediate-release oxycodone
Intermediate-acting opioids	≥ 24 Hours	*Examples*: SROM, sustained-release hydromorphone, sustained-release oxycodone
Long-acting opioids	48-72 hours and / or seek advice*	*Examples*: Methadone or fentanyl

CAMH (2021) offers the following recommendations for pharmacy initiation:

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- Prescribe 2–4 mg of bup/nlx as an initial supervised dose when the patient is in moderate to severe withdrawal (COWS ≥ 12).
- Up to 6 mg is acceptable in clinically required situations and may increase the risk of precipitating withdrawal.
- Reassess the patient after one to three hours and prescribe additional observed doses if necessary (e.g., COWS > 8, symptoms of withdrawal).
    - Be careful not to precipitate withdrawal by giving too high a dose or by medicating in the absence of observable withdrawal.
    - One or two 2 mg tablets to take home may be provided if repeated observation is not feasible in the clinical setting, with clear instructions on timing the dose to avoid precipitating withdrawal.
- Avoid prescribing more than 12 mg bup/nlx total on the first day.

While it is safe to titrate bup/nlx daily, the full clinical effect will take longer to achieve. At a constant daily dose, the serum level of buprenorphine rises over time (bioaccumulation) and the medication becomes more effective.

A clinical assessment at five to seven days will offer indications of the effect of a given daily dose. However, if a dose is clearly inadequate and there is no toxicity, the provider may increase the dose by as much as doubling it every day until a maximum of 24-32 mg/day is achieved. This is to be done in collaboration with community pharmacy and the patient is to be informed about the risk of side effects, particularly sedation. Note 24mg is the highest dose approved by HC.

British Columbia Centre on Substance Use (BCCSU, 2023) offers the following recommendations for titration:

- Select starting dose and titrate by 2mg–4mg every 1–3 hours based on withdrawal symptoms.
- Day 1 is complete once withdrawal symptoms are adequately relieved.
    - The day 1 max dose is 16mg/4mg, but higher doses may be reasonable to address persisting withdrawal symptoms.
- Prescribe the total day 1 dose for day 2. If needed, continue the same titration process and stop at a dose that adequately relieves withdrawal symptoms and cravings.
- Daily doses of up to 32mg/8mg bup/nlx may be reasonable and can be provided safely to address high opioid tolerance. 24mg is the highest dose approved by HC.

2. Home Initiation

Some patients prefer to experience moderate withdrawal in a home setting rather than in an unfamiliar health care setting. Clinical guidelines have traditionally recommended that the initial dose of bup/nlx be supervised to allow for monitoring and support for adverse effects. This may be the preferred option for

patients who are new to this medication or who would benefit from a clinician's support. However, home initiation may be considered for a well-informed patient if it is their preference.

One practical advantage with a home initiation is greater flexibility around timing. With pharmacy or clinic-based initiation, a patient might not yet have had a sufficient period of abstinence to be in moderate withdrawal when they are in the clinic, which is necessary for a standard bup/nlx initiation.

Also, the dose titration often requires that the medication be taken several times over the course of the day, which may be more convenient for a patient to do at home than in the clinic. See Appendix C for sample Home Initiation Schedules.

Home initiation follows the same dosing schedule as pharmacy or clinic initiation (i.e., first dose 2–4mg followed by subsequent doses q1–4h), but the patient is given an outpatient prescription or supply of bup/nlx to start at home when they are in sufficient withdrawal.

Before taking first dose, client is to make sure they are in opioid withdrawal. Usually, it takes several hours (12 hours or longer) after last use of an opioid to go into withdrawal. This can take even longer if methadone was taken. Encourage client to wait to take first dose of bup/nlx until they are certain they are in opioid withdrawal. Withdrawal symptoms can be assessed using the Self-assessment of Opioid Withdrawal Symptoms (SOWS)- see Appendix D.

Patients who may be particularly good candidates for home initiation include those:

- Who have previously completed a successful observed initiation with bup/nlx.
- Who have previously demonstrated capacity to take medications as prescribed, including previous OAT medications.
- Who can adequately understand the risks of sedation and precipitated withdrawal when initiating bup/nlx.
- With no regular or heavy use of alcohol, benzodiazepines, or other sedative medications (including over-the-counter medications).
- Who express willingness to come into the office or attend an emergency department if problems arise during the initiation process.
- With the ability to securely store medications.
- With stable and supportive friends or family (as defined by the patient) who may assist in supporting and monitoring the home initiation process.

Initiation Methods

Micro-dosing (Low-dose Initiation)

For many individuals, a significant barrier to starting on bup/nlx is the requirement they must be in moderate to severe withdrawal to begin taking standard doses. Micro-dosing has emerged as an alternative to traditional pharmacy initiation and involves starting bup/nlx without the withdrawal requirement. Although the research evidence is limited, clinical practice in many jurisdictions now

includes micro-dosing to reduce the risk of precipitated withdrawal, which may increase the likelihood of patient satisfaction and retention in treatment.

Also known as *The Bernese Method*, or low-dose initiation, micro-dosing involves slowly up-titrating small doses of bup/nlx, with cessation of all other opioids once a therapeutic dose has been reached. The theoretical basis for this strategy is that repetitive administration of very small doses of bup/nlx, with sufficient dosing intervals and a slow increase in the dose, can allow buprenorphine to accumulate at the opioid receptors, gradually displacing the full agonist opioids from these receptors so that withdrawal symptoms are minimized or prevented. Patients are encouraged to stop full agonist opioids when the bup/nlx dose is between 4 and 12mg.

Tip: Prescribing micro-dosing initiation to be **dispensed in blister packaging** is best practice and can help reduce patient confusion regarding doses.

Micro-dosing allows for more customized dosing but requires more intensive engagement with the care provider for several days. Providers will use clinical judgment to determine whether all-observed dosing, one observed dose and one unobserved dose per day; or all unobserved doses for several days are most appropriate for a specific patient. See Appendix E for **sample Micro-dosing Schedules**.

Clinicians might consider co-prescribing a full agonist (e.g., SROM, methadone, or as needed, hydromorphone) during the micro-dosing initiation, if clinically indicated. Benefits of initiating a patient onto SROM before the initiation of bup/nlx include helping the patient to avoid illicit opioid use while titrating up the bup/nlx dose, reducing their risk of overdose, and it may increase retention in care. **When co-prescribing a full agonist, providers are encouraged to consult experienced providers**, (e.g. Addiction Medicine Consult Service).

Macro-dosing (High-dose initiation)

At the time of this writing, macro-dosing is an evolving off-label practice. Though less common, NSH recognizes macro-dosing as an option. This rapid initiation protocol may be indicated for patients who engage in high-risk use (e.g., those that inject opioids or use fentanyl and/or high doses of opioids). Indicators for this approach are patients who are in withdrawal from fentanyl use or clients who have experienced full naloxone reversal of an opioid overdose.

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Emerging evidence suggests that a sufficiently high dose of bup/nlx may be able to push beyond precipitated withdrawal by rapidly occupying a sufficient proportion of opioid receptors and, in doing so, rapidly initiate patients to a therapeutic dose of bup/nlx. Within 1-3 hours, most patients are comfortable and feeling no withdrawal symptoms.

Although macro-dosing protocols were initially developed for settings in which some degree of monitoring is available, anecdotally, some providers are prescribing unobserved bup/nlx for macro-dosing initiations that are managed remotely. When deciding whether to use this approach, providers will consider:

- Their level of clinical experience with buprenorphine and macro-dosing,

- Their level of experience and comfort in assessing opioid tolerance, and
- The supports available, which includes the ability to connect with a patient by telephone for reassessment and the ability of the patient to seek emergency medical assistance, if required.

META:PHI (ND) resource for **macro-dosing initiation protocols** can be found in Appendix F.

Rotating Methadone to Buprenorphine-Naloxone

Some patients who show a successful and sustained response to methadone may wish to transition to bup/nlx. This is an option for patients who:

- Request more treatment flexibility with dispensing.
- Prefer to transition to LAIB.
- Are experiencing side-effects or drug-interactions on methadone.
- Wish to stop OAT but have difficulty tapering off methadone and might better tolerate a taper from bup/nlx.
- Prolongation of the QTc interval is a concern.

The decision to transition to bup/nlx must be balanced with potential risks of destabilization, which may increase when transitioning from higher methadone doses.

Options to mitigate risk include slowly reducing methadone before making the transition, micro-dosing bup/nlx (see Appendix G) or switching to SROM for five days after stopping methadone and before initiating bup/nlx.

Ongoing Buprenorphine-Naloxone Treatment

Frequency of scheduled appointments is a team decision, individualized for each client depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. It is important to strike a balance between monitoring and supporting the patient and to structure ongoing care in a way that is not overly intrusive, so that OAT remains acceptable to the patient.

Follow up visits may decrease with increasing clinical stability. Use clinical judgment to maintain an optimal individualized daily dose.

- Health Canada (Indivior UK Limited, 2021, p.8) has approved a maximum dose of 24mg and recognizes that higher doses (up to 32mg) may be necessary for some patients.
- If exceeding 24 mg, inform the patient this is a departure from approved doses and there is limited evidence of a benefit with doses higher than 24 mg (and possibly an increased risk of adverse events).

As with any chronic condition, individuals with OUD are to receive comprehensive and continuing care. This includes ongoing review and assessment of the following:

- Adequacy of dosage.
- Any emerging side effects and drug-drug interactions.

- Physical and mental health.
- Need for, and access to, harm reduction services and supports.
- Psychosocial wellbeing and need for related supports including housing, relationships, finances, and connection to cultural services and supports.

Ongoing periodic provider appointments can be used for building therapeutic relationships, providing education about harm reduction and safe injection practices, offering supports and referrals to appropriate services, and promoting health and healthy behaviours.

Missed Doses

1. For missed doses with no return to full opioid agonist use:
   - ≤ 5 days: resume previous dose
   - ≥ 6 days: adjust the dose based on the total daily dose and number of missed doses; for example:
   - If patient is on alternate-day doses, suspend bup/nlx until the patient can be reassessed. Then return the patient to a daily dose schedule, possibly at a lowered dose, to re-stabilize them before resuming an alternate-day schedule.

Table 1.3: Missed Doses of Buprenorphine/Naloxone

Missed Days	Dose	Suggested Adjustment
≥ 6 days	2 mg/0.5 mg–4 mg/1 mg	No change
≥ 6 days	6 mg/1.5 mg–8 mg/2 mg	Restart at 4 mg/1 mg
6-7 days	> 8 mg/2 mg	Restart at 8 mg/2 mg
≥ 7 days	> 8 mg/2 mg	Restart at 4 mg/1 mg

2. For missed doses due to return to full agonist opioid use:
   - Prescribing is paused with destabilization, and low-barrier access should be offered to restart therapy when desired by the patient.
   - Schedule a new initiation date and proceed as described in the Initiating OAT with bup/nlx section above.

3. For missed doses of LAIB:
   - Up to 2 weeks delay in monthly injection (i.e., up to 42 days after last dose): Occasional delays of up to 2 weeks are not expected to significantly impact treatment effect. If a patient misses a monthly injection, they are to receive their next dose as soon as possible, and monthly injections should be resumed thereafter.
   - More than 2 weeks delay in monthly injection (i.e., >42 days after last dose): Re-initiation is warranted. Patient is to be restarted on sublingual bup/nlx followed by a rapid transition to LAIB (see General initiation and dosing information above).

Dispensing Frequency

All patients are eligible for weekly dispensing of bup/nlx once started on treatment, unless the clinical care team has determined that it is unsafe to do so (e.g., unable to safely store medication, co-occurring sedative or alcohol use disorder (AUD) compromising patient's safety). There should be documented clinical rationale if witnessed ingestion of bup/nlx is required.

Patients can progress from weekly to every other week dispensing after completing two months of random urine drug screens (UDS) (one random per month) with no non-prescribed substance use.

Patients on bup/nlx who travel for employment, education or recreational purposes will be assessed on a case-by-case basis to determine dispensing quantity above this amount. Use clinical judgement when determining dispensing frequency for this purpose.

All patients with bup/nlx doses dispensed are required to sign an OAT dispensing frequency agreement (see Appendix H) outlining patient's rights and responsibilities. Clinical team will review expectations and rights and responsibilities of patients to ensure patient can safely store medication.

Consider longer-interval dispensing frequency when the patient:

- Most importantly, can safely store bup/nlx in compliance packaging provided by pharmacy, and/or a lockbox (especially in household with children). A lockbox is not required for bup/nlx. Compliance packaging is considered best practice.
- Is not currently serving an intermittent sentence with corrections (i.e., weekends).
- Has no documented incidents of over sedation, intoxication, hospitalization or concerns of alcohol or benzodiazepine use compromising patient safety.
- Has reasonable and consistent access to a means of communication with the treatment team.

Consider shorter interval dispensing frequency when you estimate the benefits are exceeded by the risk of:

- Toxicity from dosing errors.
- Harm to others in the patient's environment from access to the patient's OAT.
- Therapy becoming ineffective due to medication non-adherence,
- Victimization of the patient by others in their environment.

These risk estimations should consider the possibility of:

- Substance interactions (prescribed; non-prescribed; over the counter; illicit; licit, including alcohol).
- Un/intentional diversion and possible exposure to susceptible individuals.
- Precarious social situations.

Note: The Nova Scotia Pharmacy Regulator (NSPR) Standards of Practice indicate that bup/nlx self-administration must be observed by a pharmacy team member unless otherwise noted on the prescription. If the patient is to remain under observation until the medication has dissolved (witnessed dispensing), this also must be indicated on the prescription.

Missed Prescription Pick-up

If a patient misses more than 1 pick-up day in a period of 2 months, consider a team discussion to consider whether a different interval in dispensing frequency would benefit the patient.

Urine Drug Screen (UDS)

UDS is an important part of providing care to individuals with SUDs, from confirming baseline substance use to evaluating treatment outcomes. However, many individuals have had negative experiences with UDS. When UDS procedures are perceived as punitive, it can impact whether an individual will continue to access care.

UDS are one tool that can be used to monitor and assess adherence to treatment, validate self-reported use of opioids or other substances, detect use of other substances that may increase risk for overdose (e.g., benzodiazepines), and evaluate treatment response and outcomes. However, as the extent of their utility and effectiveness is unclear, UDS results alone are insufficient to diagnose OUD. Screening tests are immunoassay (point-of-care (POC), or in the lab) and are subject to false positives and negatives. Confirmatory tests are usually liquid chromatography/tandem mass spectrometry (gold standard).

Through clinical judgement, other ways to assess and determine OUD include but are not limited to:

- Assessment of client presentation. Do they appear sedated? Have they missed appointments? Has their level of engagement changed?
- Signs of recent injection marks.
- Seeking collateral indications from family members, primary care provider, community pharmacy staff, etc.

The application of UDS is to be discussed with the patient and be based on the principles of improved patient care and outcomes. The frequency of testing will be determined by therapeutic need, understanding that more frequent UDS has not been shown to decrease substance use; however, a general principle of 'more frequent testing at the beginning of treatment' may be followed. Although urine samples will be supervised in clinical ORP settings, witnessed UDS may contribute to stigma, be experienced as a privacy violation, and should be avoided.

UDS are to be used for specific purposes, such as to:

- Confirm unregulated opioid use during baseline assessment.
- Support decision-making regarding dispensing frequency.
- Confirm that the medication is being taken.
- Screen for ongoing non-prescribed or unregulated opioid use, which may indicate the patient is undertreated or needs additional support.
- Detect the presence of other substances, including substances the patient may be unaware they have ingested.
- Evaluate treatment response and outcome.

When unexpected urine drug test results occur, and/or when a client disputes the results of UDS, further exploration with the team to review the overall clinical picture is to take place. Before changing the

treatment plan, it is critical to discuss the unexpected results with the lab, the care team, and the patient. This reflection on safety may lead to an increased level of monitoring, and/or more frequent appointments for the next while. It is also recommended to repeat the POC-test immediately (using a test from a different box).

Table 1.4: UDS Schedule for Patients Prescribed Bup/Nlx

Treatment Stage	UDS Schedule for Patients Prescribed Bup/Nlx
Initial UDS	Not required to diagnose OUD but helps to confirm opioid use. Discussion of results can be useful to build rapport with patient and help reduce risk to the client, especially given the increased risk during the first couple of weeks of initiating OAT.
Initiation / Stabilization	Suggest weekly UDS for at least the first month, at the discretion of provider and for purposes of monitoring.
Ongoing	Frequency of scheduled appointments is a team decision, individualized for each client depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. It is recommended that UDS be completed at time of scheduled appointments as a tool for open communication. If client is unable to provide a sample, they should still be seen for their appointment. In addition, it is also recommended to request four (4) random UDS per year. If requesting more frequent random UDS, this should be clinically indicated and documented.
Dispensed Medication	Patients can progress from weekly (standard for bup/nlx) to every other week dispensing after completing two months of random UDS (one per month) with no non-prescribed substance use.

Safety

Lock boxes are recommended (though not required) for the safe storage of bup/nlx doses to prevent children and others from ingesting fatal doses. The ceiling effect of bup/nlx for respiratory depression only applies to adults and therefore children are at higher risk if they ingest bup/nlx.

Patients are required to present compliance packaging quarterly, or less frequently at the discretion of the provider, to the ORP clinic for random pill counts at time of UDS. See below for further guidance around UDS.

If there are safety concerns regarding sedation, diversion or safe storage, the care team has the flexibility to reduce the amount of medication dispensed at a time, and/or implement more frequent random UDS and pill counts to ensure safety guidelines are met.

Missed Random Pill Counts

If a patient does not attend their random pill count within the designated 48 hours, they will be asked to return for a clinic appointment and team discussion. Do not assume that all doses were diverted or that the individual has destabilized.

The team will decide collectively on how to proceed, allowing flexibility to tailor the client's care based on the circumstance. The next potential steps could include:

- Clarifying random pill count expectations and responsibilities.
- Collecting a collateral history from family or community pharmacy.
- Increase pill count monitoring to monthly.
- Shorten length of time between clinic appointments.
- Increase frequency of UDS.
- If there is evidence of diversion, return to a shorter dispensing interval with reassessment of dose.

If Patient Reports Doses Have Gone Missing

When the care team decides to replace the missing doses, new doses must be witnessed daily.

Prior to returning to the previous dispensing interval, the ORP team will reassess the individual's stability factors with a focus on safe storage of medication.

Repeated incidents of missing doses will result in a team discussion and possible return to witnessed dosing at the community pharmacy.

Tapers

OAT is an open-ended treatment. However, if a patient wishes to discontinue medication following a sustained period of stability on OAT (12 months or more preferred), a slow taper will be offered. Prescribing will only be stopped abruptly in cases of acute overdose, allergic reaction or clear diversion of a medication. If a patient has been taking their prescribed medication, **abrupt termination will lead to opioid withdrawal.**

Following OAT termination, subacute withdrawal symptoms can persist for months; however, most patients relapse to other opioid use or resume OAT before withdrawal becomes unmanageable.

Consider the following:

- Individuals who discontinue OAT are at increased risk of return to unregulated opioid use and related harms including drug toxicity death. Clinicians will discuss these risks with patients and advise ongoing engagement in treatment.
- Patients who expressly wish to discontinue treatment will be advised to consider a gradual taper that extends for as long as possible.
- Longer bup/nlx tapers (28- 56 days) have been associated with improved outcomes at completion (abstinence from non-medical opioid use, retention in treatment) compared to shorter bup/nlx tapers (7- 28 days).

- Evidence suggests that a longer time in treatment prior to initiating the taper (>52 weeks vs. <12 weeks) shows higher rates of successful taper and lower risk of subsequent opioid overdose.(BC Centre for Substance Use and Addictions, 2023)
- An opioid agonist taper involving bup/nlx appears to reduce the severity of withdrawal symptoms, and most patients still relapse to opioid use if a strategy involving only withdrawal management is employed.

Buprenorphine may offer some advantages over methadone when used during a taper, specifically offering faster symptom relief. There does not appear to be a significant difference in terms of withdrawal symptom severity, withdrawal treatment completion, or average treatment duration for individuals managed with bup/nlx compared to methadone.

- With methadone, the onset of acute withdrawal is usually over a period of 24 to 72 hours and peaks three to four days after the last dose. It can last for 15 to 20 days.
- With bup/nlx, the onset of acute withdrawal is typically closer to 48 hours, with a peak at three days and a duration of 10 days.

Compared to alpha2-adrenergic agonists, bup/nlx appears to offer more effective relief of withdrawal symptoms, as indicated by the lower overall withdrawal score, longer retention in treatment, and greater likelihood of completing treatment. There does not appear to be a significant difference between bup/nlx and alpha2-adrenergic agonists in adverse effects except in comparison with clonidine, which is associated with higher rates of drop-out due to side effects.

Section 2: Methadone

Introduction

Based on recent national recommendations, emergent evidence and best practices, MHAP's new guidelines for prescribing methadone in MHAP are intended to help shift outdated, unsupported, and potentially stigmatizing legacy prescribing practices. The goal is to support decision-making that is individualized and based on discussion between the care provider and person taking methadone, in the context of a therapeutic relationship.

Methadone is arguably the most well-known and long-standing of the three OAT medications available to treat OUD in Nova Scotia. Historically, methadone prescribing practices were guided by the Methadone Maintenance Treatment (MMT) Handbook created by the Nova Scotia College of Physicians and Surgeons. Retired in 2017, the MMT Handbook offered a structured approach to methadone management regarding dose initiation, titration, and dispensing frequency (also known as take-home doses, unsupervised doses or carries).

As with all OAT medications, methadone is prescribed in a way that balances the risk of adverse effects to the patient and people in their environment while optimizing the benefits, including retention in treatment and decreased health and quality-of-life harms related to substance use.

Considerations

ECGs are not required for baseline assessment, nor is waiting for confirmatory testing before starting patient on OAT. However, **ECG may be indicated for some patients on methadone**.

For benefits, risks, side effects and adverse reactions, see Appendix A: Decision Support Tool for Selecting OAT and/or the product monograph (Paladin Labs Inc., 2014). Providers are encouraged to document their rationale for selection of OAT medication.

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Pharmacology

- Peak plasma levels are achieved within 2.5-4 hours.
- Elimination half-life: The steady-state elimination half-life of methadone is approximately 25 hours. Large inter-individual variability in elimination half-life may necessitate 2 to 9 days for steady-state serum levels.
- Acutely, methadone has similar effects to other opioids; however, its pharmacological properties are significantly different from other opioid agonists in that it is extremely long acting (36 to 48 hours) in humans. After interruption of chronic dosing, if methadone treatment is to be continued, starting doses should be low and patients should be titrated slowly to effect to avoid severe toxicity and respiratory depression
- Methadone's equivalency potency as compared with other opioids can be unpredictable.

Methadone Formulations Available in Nova Scotia

In the context of OUD, individual patient doses are prepared from a commercially available 10mg/ml stock solution and are diluted to a uniform volume of 100mL with a suitable diluent, preferably Tang®. Compound stock solution should only be used when suitable commercially available products are either unavailable or unsuitable for the patient. (NSPR, 2024)

While methadone tablets are available for the management of severe chronic or malignant pain, **they are not indicated for the management of OUD**.

Administration

In most cases, methadone is **administered once daily**.

Methadone solutions **must** be dispensed in 100 mL of a vehicle that does not easily lend itself to injection. Excerpt from product monograph (Paladin Labs Inc., 2014):

- METADOL (Oral Solution and Concentrate) has been found compatible with 100 mL of the following diluents prepared, where applicable, according to the manufacturer's instructions:
    - Grape flavoured Kool-Aid®
    - Orange flavoured Tang®
    - Allen's® Apple Juice
    - Crystal Light® Tangerine-Grapefruit flavoured
    - Crystal Light® Lemonade flavoured

  ®Tang, Kool-Aid and Crystal Light are registered TMs of Kraft Foods, Inc., Northfield, Illinois.
  ®Allen's is a registered TM of Cadbury Beverages B.V., Amsterdam, Netherlands.
- Diluted solutions should be refrigerated (2°C to 8°C) and stored for a period not exceeding 7 days in Allen's® Apple Juice, and 14 days in all other diluents mentioned above.

Initiating OAT with Methadone

Prior to initiation, review risks and benefits of treatment (see Appendix A), determine starting dose based on patient-specific risk of opioid toxicity (see Table 2.1), and obtain informed consent. **If there are concerns of methadone toxicity**, the Most Appropriate Health Care Provider will see the patient at 3-hours post-dose.

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During initiation, providers should see patients at least weekly to carefully monitor treatment response. Depending on the patient's needs and circumstances, these assessments can be conducted in person or virtually. During the first two weeks of treatment, patients are at the highest risk of fatal overdose, including those not using illicit substances. Discuss strategies to reduce the risks (e.g., use only small amounts of additional opioids; do not use alone; have a naloxone kit available; reach out to the clinic for additional support as needed). Providers may consider requesting a naloxone kit along with the initial prescription.

For additional information on where/how to get a naloxone kits visit the Take Home Naloxone Program.

The starting methadone dose will depend on factors that affect risk of toxicity, including the patient's known opioid tolerance, current opioid use, and co-occurring substance use patterns.

A slower dose escalation should be considered for:

- Individuals who may be at higher risk of opioid toxicity, including individuals with
    - Recent loss of tolerance (e.g. recent discharge from withdrawal management, residential treatment, or correctional facilities where they did not receive OAT)
    - Severe respiratory illness
    - Decompensated liver disease
- Individuals with increased risk for QTc prolongation (e.g. heart disease)
- Individuals using substances or prescribed medications that interact pharmacodynamically and/or pharmacokinetically with methadone (e.g. alcohol, benzodiazepines, CYP inhibitors)
- Older adults (i.e., over 55 years of age)

Fentanyl use affects the initial dosing and titration. Considering the accumulating clinical experience and emerging guidance, this guideline endorses a starting dose of up to 40mg for individuals who use fentanyl and have established tolerance to methadone based on past treatment history.

Due to risk of overdose from drug-to-drug interactions, care providers are encouraged to review current substance use (including alcohol and prescription medications) with patients at every visit and confirm with the DIS, when possible. Any assessment of known drug interactions would be beneficial if provided to the pharmacy. Where possible, the recommendation is that providers check DIS, or Prescription Monitoring Program (PMP), at every appointment (or at minimum every 3 months).

Clinical assessment is necessary before adjusting methadone doses; this is due to the unique pharmacokinetic properties of methadone (long half-life, slow bioaccumulation) compared to other opioids, and the high degree of individual variability in absorption rates, metabolism, potency, and cross-tolerance with other opioids. For example, patients with previous treatment experience with methadone face a lower risk of complications during initiation and may be good candidates for virtual.

Titration

Patients are seen in person, or virtually, at least weekly during titration. Providers and/or ORP staff are also encouraged to collaborate with dispensing pharmacy, especially during titration.

Before adjusting methadone doses, clinical assessment is necessary due to:

- Long half-life, slow bioaccumulation.
- High degree of individual variability in absorption rates, metabolism, potency, and cross-tolerance with other opioids.
- Changing substance use patterns, including alcohol and prescription medications (when possible, confirm through DIS or PMP).

For Table 2.1, the rate of titration can be adjusted based on the patient's presentation. **Higher or lower doses may be considered on a case-by-case assessment** of risks and benefits; rationale should be documented.

Table 2.1: Initiation and Titration of Methadone at start of OAT Treatment (adapted from (BCCSU, 2023)			
Opioid Tolerance / Risk for Toxicity	**Examples**	**Suggested Starting Dose**	**Titration**
No* / Low tolerance or **high risk for toxicity**	Includes patients: - With recent loss of tolerance (e.g., withdrawal management, incarceration). - Not currently using opioids but at risk of relapse. - With heavy use of other sedating agents. - With severe comorbidities that affect toxicity risks.	10 mg / day	10 mg every 3 days. When dose reaches 60 mg, slow titration.
Moderate tolerance or **moderate risk for toxicity**	Includes patients: - Who use benzodiazepines or other sedatives (prescribed or unprescribed). - With AUD.	20 mg / day	
High tolerance **low risk for toxicity**	Includes patients who use opioids regularly.	30 mg / day	15 mg every 3 days. When dose reaches 85 mg slow titration to 10 mg every 3-5 days.
Known very high tolerance or very **low risk for toxicity**	Characterized specifically by previous methadone experience and current fentanyl use.	40 mg / day	

* If no or unknown tolerance, do not recommend automated dose increases. Check in more frequently.

Co-prescribing Methadone and SROM

For people with high opioid tolerance who are choosing to start methadone as their primary OAT, co-prescribing SROM has been suggested as an option to achieve effective therapeutic OAT doses more rapidly, as maximum initial methadone doses have historically been capped at 30 mg. In this context, the usual starting dose of SROM is 100- 200 mg along with 30 mg of methadone. Dose titration is typically in increments of 100 mg every 48 hours. SROM can be continued or tapered once the methadone dose is stable (Cheema et al., 2023, p.14).

When co-prescribing SROM and methadone during initiation, there is an elevated risk of overdose during the first four weeks. Close monitoring is recommended.

- SROM is dispensed as "observed dosing along with methadone" (Cheema et al., 2023)
- Use a maximum SROM starting dose of 200 mg; adjust upward by 50 mg at a time to a maximum of 300 mg and maintain or taper depending on clinical response. (CAMH, 2021; Selby et al., 2022)

Switching OAT Medications

When a shared decision between provider/team and patient is made to change OAT medication, the process must be planned when possible and involve the team, documenting the clinical reasoning in the patient's health record.

Switching (also called 'rotating') from one to another OAT medication may be considered when:

- Current treatment has not impacted, or has worsened, non-prescribed opioid use.
- Current treatment has had a negative effect on other substance use.
- It helps to simplify treatment or increase flexibility.
- Other factors increase risk of harm to the patient, or impact health, wellness, or quality of life.

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Switching FROM another OAT Medication TO Methadone

The tables below offer guidelines for switching OAT medications based on a flexible approach to care. The rate & ratio of the cross-taper can be adjusted based on patient's clinical presentation.

Table 2.2: Switching FROM another OAT Medication TO Methadone	
To Methadone from Bup/nlx	For sublingual, stop bup/nlx immediately. Start initiation of Methadone dose within 24 hours of the last dose of bup/nlx. For LAIB*, monitor for withdrawal symptoms and treat accordingly.
To Methadone from SROM	Cross-taper approach is preferable. - Replace 100 mg of SROM with 10 mg of methadone (10:1). - Increase methadone and decrease SROM concurrently, every 3 days.

*A future version of MHAP OAT Guidelines will include more information about LAIB.

Switching FROM Methadone TO another OAT Medication

When rotating from methadone to buprenorphine/naloxone (bup/nlx), clinicians are encouraged to counsel patients on the risk of precipitated withdrawal. See bup/nlx Section: Precipitated Withdrawal.

There is a discrepancy in replacement ratios because methadone has a prolonged and variable half-life and regular dosing increases the potency.

Table 2.3: Switching FROM Methadone TO another OAT Medication	
From Methadone to Bup/nlx	Microdosing / low-dose rotation is preferred. Other bridging strategies used for methadone to bup/nlx can also be applied
From Methadone to SROM	Cross-taper approach is preferable. - Replace 10 mg of methadone with 80 mg of SROM (1:8). - Decrease methadone and increase SROM concurrently, every 3 days.

Ongoing Methadone

The goal is to stabilize the daily dose at the lowest dose that relieves withdrawal symptoms, reduces cravings, and suppresses unregulated opioid use, while not causing sedation or toxicity. Use clinical judgment to determine an appropriate maintenance dose.

Consider tapering down the dose for patients experiencing opioid-induced side effects (e.g., sweating, hypogonadism, severe constipation, adrenal insufficiency) and collaborate with the patient to balance the benefits, disadvantages and risks of methadone treatment.

Split Dosing Considerations

Methadone's long half-life typically allows for once-daily dosing. However, a growing body of clinical evidence suggests that some patients may benefit from twice daily ("split dosing") to produce more stable symptoms and minimize side effects (Braun & Potee, 2023).

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Split dosing often requires providing evening doses as dispensed doses because few patients will be able to attend a pharmacy twice daily for witnessed dosing. Consider clinical stability before offering split dosing and consult with experienced colleagues on such challenging cases. There is no consensus on the best way to assess the need for split dosing.

Assess for post-dose sedation at peak serum levels for patients on high doses of methadone by arranging a witnessed dose in the pharmacy, with a follow-up in the clinic two to four hours later.

If rapid metabolism is suspected, consider confirmation with serum methadone levels (with peak/trough ratios > 2:1, if available).

Dispensing Frequency

Access to dispensed methadone has potential benefits to patients that include treatment retention, decreased treatment disruption, and improvements in clinical and social stability. Care providers have flexibility when determining methadone dispensing intervals. Table 2.4 offers recommendations for the dispensing frequency of methadone.

Given the risks associated with dispensed doses, clinical decisions must carefully weigh the risks and benefits of unwitnessed methadone to patients and the community against those of attending a pharmacy more regularly.

Decisions about dispensing are based on an assessment of the individual's clinical and psychosocial stability and their ability to store and manage dispensed doses safely. Consider factors like how far the patient lives from their pharmacy, the person's work or school schedule, other responsibilities the patient has, holidays, emergencies, and so on.

First dose of each methadone dispense is witnessed.

Table 2.4: Dispensing Frequency of Methadone (adapted from BCCSU, 2023)		
# Dispensed Doses	**Min. Time in Treatment**	**Appropriate When / For**
0 Not a candidate for dispensed doses.	-	Any of: • Inability to safely store medication, • Unstable psychiatric illness or other acute mental health crisis, • Frequent missed doses and appointments, • Ongoing high-risk or uncontrolled substance use* patterns.
Up to three non-consecutive dispensed doses per week	4 weeks	All of: • Able to store medication safely • Ability to keep appointments and manage medication, • No high-risk or uncontrolled substance use patterns that cause frequent drug poisoning, blackouts, or other severe safety risks, • No acute behavioral or psychiatric issues at point of assessment.
Four to six dispensed doses per week	12 weeks	All of: • Appropriate management of non-consecutive dispensed doses, • Improved clinical and psychosocial stability, including: - Rare, missed appointments, - Minimal unprescribed substance use, in alignment with treatment plan and individual goals, with no recent drug poisonings, or blackouts.
Seven to fourteen dispensed doses at a time	Exceptional circumstance	All of: • Long-standing and very consistent stability, • Experience with successfully managing dispensed doses, and • Typically to support unique situations (e.g., travel for employment or leisure).

*E.g., The use of alcohol and/or benzodiazepines with opioids creates a higher risk for respiratory depression.

Considerations to Guide Decisions About Dispensing Frequency (also known as 'stability factors')

- Attendance at and engagement during appointments.
- Few missed doses.
- Safe living environment.
- Safe storage of medications.
- Stable mental health.
- Starting to use substances in a less risky way.

Patients who regularly miss doses require reassessment. Clinicians will assess the risks, benefits and barriers for that individual and determine if any adjustments are needed in dispensing frequency.

Missed Doses

Methadone is safest when consistently taken as prescribed. Frequent missed doses can be dangerous. **Four (4) or more consecutive missed doses leads to loss of tolerance** for which the dose of methadone

should typically be reduced. Missed doses can also cause symptoms of opioid withdrawal; these symptoms could cause a person to consume their dispensed doses too quickly, increasing the risk of oversedation and/or overdose.

Missing doses can be an indicator of instability. Frequent missed doses will prompt discussion and problem-solving around the reasons for missed doses. For example, pharmacies may have restricted hours on Sundays, making it difficult for individuals to receive their methadone. A single weekly dispensed dose, or a different pharmacy, may resolve this problem and prevent ongoing missed doses.

Table 2.5: Missed Doses of Methadone	
Consecutive Days Missed	**Dose**
3 (patient presents on Day 4)	Continue previous dose.
4 (patient presents on Day 5)	Cancel prescription. Reassess. **Can restart at 50%** of previous dose or initiation dose (whichever is higher)
5 (patient presents on Day 6)	Cancel prescription. Reassess. **Re-start** titration.

Monitoring

When prescribing methadone, providers are **strongly encouraged** to request UDS and medication checks. Recommended frequency of monitoring is outlined in Table 2.6. The notification process is the same for all OAT medications.

Medication Checks (Bottle Audits)

Random bottle audits are required for dispensed methadone. This critical monitoring may be done by the pharmacy (***if*** the community pharmacy has capacity and has agreed).

Urine Drug Screen (UDS)

Table 2.6 outlines the recommended UDS Schedule for patients that are prescribed methadone.

Table 2.6: Monitoring Frequency	
Treatment Stage	**UDS Schedule for Patients Prescribed Methadone**
Initial UDS	Not required to diagnose OUD but helps to confirm opioid use. Discussion of results can be useful to build rapport with patient and help reduce risk to the patient, especially given the increased risk during the first couple of weeks of initiating some OAT.
Initiation / Stabilization	**Suggest weekly UDS for at least the first month,** at the discretion of provider and for purposes of monitoring.

Ongoing	Frequency of scheduled appointments is a team decision, individualized for each patient depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. When possible, it is recommended that UDS be completed at time of scheduled appointments as a tool for open communication. If patient is unable to provide a sample, they should still be seen for their appointment.
Dispensed Medication	**Random UDS are required for dispensed methadone**. **It is recommended to request an additional six (6) random UDS per year.** More frequent UDS should be clinically indicated, and results should not be used in a punitive way. Alternative UDS frequency (i.e., greater frequency) can be determined by team based on individual patient assessment.

Safety

Dispensed methadone must be kept safe as diversion poses a public health risk. Methadone becomes accessible within the community when dispensed doses are improperly stored, lost, stolen, shared, traded, or sold.

Methadone's formulation – dispensed in a beverage that should be refrigerated – poses an additional risk to children, because it is more likely than capsules or tablets to be taken accidentally. For example, unsecured dispensed doses can be consumed by children in the vehicle on the way home from the pharmacy. This is why lockbox storage is required.

Decision Support

When making decisions about dispensing frequency, the care provider and the patient being prescribed methadone will discuss the risks of unintentional methadone diversion and ingestion, documenting assurance that medication can be safely stored.

Care providers with less experience prescribing methadone are encouraged to consult a more experienced colleague.

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Safe Storage

All persons receiving dispensed doses of methadone must store them where others cannot access them. **Lockboxes are required for dispensed methadone**. If patient does not have access to a lockbox and this is a barrier to treatment, the ORP clinic will provide one. In exceptional circumstances, if a patient is prescribed more than six dispensed doses, a second lockbox may be needed.

Missed Random Medication Checks

If a patient is considered to have **missed the random medication check (bottle audit), the patient will return to DWI on their next pick-up day at pharmacy until contact is made with ORP clinic**. The patient will

be asked to return for a clinic appointment and team discussion. Clinicians and providers are encouraged to approach the conversation with non-judgmental curiosity, rather than assuming that doses were diverted, or the individual has destabilized. Next steps will be determined through clinical judgement.

The suggested window to request random monitoring is 48 hours. If a client presents beyond the requested 48-hours, it is recommended to proceed with UDS and medication checks- "late" is not the same as "skipped". The information garnered is still useful, both in terms of the test/audit result, and the effort made to comply. A hard cut-off is seldom beneficial.

If Patient Reports Doses Have Gone Missing

When the care team decides to replace the missing doses, new doses must be witnessed daily.

Prior to returning to the previous dispensing interval, the ORP team will reassess the individual's clinical stability with a focus on safe storage of medication.

Repeated incidents of missing doses will result in a team discussion and possible return to witnessed dosing at the community pharmacy.

Section 3: Slow-Release Oral Morphine (SROM)

Introduction

Among the various pharmacological interventions available for OUD, SROM has emerged as a valuable option for OAT. **Through a collaborative process involving informed consent, the provider and patient together may determine SROM to be the most suitable OAT medication for the patient.**

SROM has a growing body of evidence for its use as an OAT medication and has been used off-label in Canada to treat OUD since 2017. It has been compared to the other OAT medications and limited evidence led to the conclusion it is acceptable for use in OUD clinical management. When prescribed for the treatment of OUD, SROM is eligible for coverage under Health Canada's Non-Insured Health Benefits (NIHB) program and is a regular benefit under Nova Scotia's provincial drug plan (Pharmacare).

The evidence supporting the use of SROM for OUD has limitations, including a relatively small body of evidence of low-to-moderate methodological quality when compared to buprenorphine-naloxone (bup/nlx) and methadone. Little and low-certainty evidence suggests that treatment retention was similar in patients receiving SROM compared to patients receiving bup/nlx or methadone. Because evidence is limited and emerging, and due to concerns over added risk, SROM is used with caution as a treatment for OUD with precautions that include daily witnessed dosing and close monitoring.

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If a patient requests SROM for chronic pain, in addition to the management of OUD, the provider may choose to seek decision support from an experienced colleague or the AMCS.

Considerations

Selecting SROM as the preferred treatment approach may be suitable for individuals with:

- Severe OUD and/or higher-risk opioid use (e.g., fentanyl).
- Ongoing cravings, withdrawal symptoms, and/or high-risk opioid use with other types of OAT.
- Side effects (e.g., sedation, nausea) and/or drug interactions with other types of OAT.
- Contraindications to other OAT medication.
- Co-occurring chronic pain.

During physical examination, consider the following:

- Pupillary changes.
- Signs of skin and soft tissue infection.

- Respiratory signs.
- Signs of heart failure or valve dysfunction.
- Stigmata of chronic liver disease.

For benefits, risks, side effects and adverse reactions, see Appendix A: Decision Support Tool for Selecting OAT. Consider utilizing colleagues with more expertise, as appropriate, including the AMCS.

Additional risks associated with SROM:

- The slow-release design of SROM can be circumvented by chewing or crushing the pellets to release the entire morphine content as a bolus dose of short-acting morphine.
- Co-ingestion with alcohol can also lead to rapid absorption of the dose.
- SROM capsules can be crushed and dissolved for injection, with high risk of ensuing infection. There is emerging concern over added risks of this formulation beyond the usual risks associated with IV drug use. If there is concern about compliance with dispensed doses, consider prescribing alternative OAT medication.

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When prescribing SROM, providers are encouraged to ensure patients understand the risks, especially those associated with injection.

See Appendix I for excerpts from BCCSU's Resource for Safer Tablet Injection(BCCSU et al., 2021)

Pharmacology

- SROM is administered via once-daily oral doses.
- SROM is released over 24 hours.
- Peak plasma levels are achieved within 8.5 to 10 hours.
- Elimination half-life: The terminal elimination half-life of morphine following a single dose of SROM administration is approximately 11 to 13 hours. However, this is primarily due to the delayed absorption of the pellets. Once absorption is complete, the plasma elimination half-life is the same as immediate-release morphine (2 to 4 hours).

Note: Use caution when prescribing SROM to individuals with significant renal impairment due to possible accumulation of Morphine-6-glucuronide. For more information, see the product monograph (BGP Pharma ULC, 2015) and/or BC Renal Agency's Renal Analgesic Brochure (2011)

SROM Formulations Available in Nova Scotia

Only the once-daily, 24-hour formulation of SROM has been studied in clinical trials for the treatment of OUD. Other formulations, such as twice-daily, 12-hour sustained- or extended-release formulations have not been empirically studied in this context and are not recommended at the time of publication.

Note: The largest dose form of Kadian™ is 100 mg, therefore the higher the dose, the greater the number of beads.

More information may be found in the Nova Scotia Department of Health and Wellness Formulary (2025)

Administration

The SROM capsule is to be opened prior to administration and the pellets provided to the patient to swallow whole, with water unless otherwise directed by the provider. Crushing, chewing, or dissolving capsules or pellets can cause rapid release and absorption of a potentially fatal dose of morphine sulphate.

Following the ingestion of SROM, drinking water is preferred to acidic beverages (e.g., cola, sparkling water, coffee, orange juice), as acidic liquids may affect the absorption kinetics of the medication.

Pharmacy practitioners are responsible for determining the proper method of administering prescriptions for SROM, such as whether capsules should be opened or taken whole. If this information is not specified, they must seek clarification from the provider. NSPR Standards of Practice: Drug Therapy for the Treatment of Opioid Use Disorder (2024)

Initiating OAT with SROM

The clinician should work together with the patient to select the most appropriate OAT for the individual (CRISM, 2024) All OAT medication options are to be considered based on the individual's needs and goals. Part of informed consent is knowing (or understanding) all the options. See Appendix A: Decision Support Tool for Selecting OAT for guidance.

Conversation points for patients who want to initiate OAT with SROM:

- SROM is more restrictive than bup/nlx and methadone. Dispensing is usually daily over the long term.
- Due to the added risk, many safeguards are in place, including a higher level of monitoring with SROM than other OAT medications.
- Not all pharmacies keep SROM in stock which may cause delay in patient access to the medication. This is also important to consider when patients need to utilize an alternative pharmacy.
- Patients who are prescribed SROM will need to discuss alternative dispensing strategies with their ORP team to mitigate risk when access to the medication may be a factor.
- SROM is typically prescribed for pain. Prescribing SROM for OUD is "off-label use" however is a recognized treatment for OUD (BCCSU 2023; CRISM, 2024; Cheema et al., 2023)

Initiation and Titration Dosing

During initiation, prescribers should see patients at least weekly to carefully monitor treatment response. Depending on the patient's needs and circumstances, these assessments can be conducted in person or virtually. During the first two weeks of treatment, patients are at the highest risk of fatal overdose. Discuss this risk and strategies to reduce it (e.g., use only small amounts of additional opioids; do not use alone; have a naloxone kit available).

As with all OAT, the optimal dose aims to manage withdrawal symptoms and cravings for 24 hours without sedation or undue side effects. SROM starting doses should be based on the individual's opioid tolerance and risk of toxicity. Because of the sustained-release properties of SROM, dose increases are separated by 48 hours. The initiation and titration protocols were developed based on clinical experience of prescribing SROM in OUD treatment settings (see Table 3.1).

Re-assessment of patients before titration is critical. Provider can reassess in a variety of ways: in person, virtual, over the phone, and/or in consultation with the pharmacy team. Also consider gathering collateral information within the circle of care and with permission among the circle of support.

Use clinical judgment to determine each dose increase. Consider the opioid(s) the patient is using, their level of tolerance to opioids and the risk of toxicity or compliance concerns versus the risk of lower treatment retention.

It is important for the patient to have at least two (2) consecutive doses at the same dose before titrating up. Also important not to continue that pattern of titration past the previous stable dose, if known. At that point, **weekly dose adjustments are required**. At times, more rapid titration may be required. This is to be done with clear documentation of clinical reasoning, informed consent, and consultation with an experienced provider.

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There is no defined maximum dose for SROM. The highest dose described in the literature to date is 1200 mg; however, clinical experience indicates that patients often require doses above 1200 mg to manage cravings and withdrawal symptoms, due to high tolerance developed because of sustained exposure to fentanyl through the unregulated drug supply. Use caution with respect to side effects when prescribing higher doses (e.g., above 1200mg) and clearly document the rationale.

If the initiation dose exceeds that recommended in the table below, communicate with the dispensing pharmacist and document your clinical reasoning.

Table 3.1: Initiation and Titration of SROM at start of OAT Treatment (adapted from BCCSU, 2023)

Opioid Tolerance / Risk for Toxicity	Examples	Suggested Starting Dose	Titration
No / Low tolerance or **high risk for toxicity**	Includes patients: - With recent loss of tolerance (e.g., withdrawal management, incarceration). - Not currently using opioids but at risk of relapse. - With heavy use of other sedating agents. - With severe comorbidities that affect toxicity risks.	50 mg *	50 mg every 48 hours
Moderate tolerance or **moderate risk for toxicity**	Includes patients using opioids regularly or those with risk of toxicity due to benzodiazepine or alcohol use.	100 - 150 mg	50 mg – 100 mg every 48 hours
High tolerance **or lower risk for toxicity**	Includes patients who use fentanyl regularly and/or have very high opioid tolerance (e.g., 1500 MEQ). For patients with previous SROM experience and current fentanyl, consider higher dose.	200 mg *	100 mg - 200 mg every 48 hours up to 800 mg ***Thereafter***: 50 – 200 mg every 48 hours

*__Higher or lower doses may be considered__ on a case-by-case assessment of risks and benefits; rationale should be documented.

Switching OAT Medications

When a shared decision is made to change OAT medication, the process must be planned when possible and involve the team, documenting the clinical reasoning in the patient's health record.

Switching (also called 'rotating') from one to another OAT medication may be considered when:

- Current treatment has not impacted, or worsened, non-prescribed opioid use.
- Current treatment has had a negative effect on other substance use.
- It helps to simplify treatment or increase flexibility.
- Other factors increase risk of harm to the patient, or impact health, wellness, or quality of life.

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Switching FROM another OAT Medication TO SROM

Current literature suggests patients who are intolerant or do not respond sufficiently to other OAT medications can transition to SROM with relative ease (Cheema et al., 2023). The transition is typically well-tolerated by patients, with significant advantages observed over time, including reduced withdrawal symptoms and cravings, and improved physical and psychological health (see Appendix A).

Table 3.2 and 3.3 offer guidelines for switching OAT medications based on a flexible approach to care. The rate & ratio of the cross-taper can be adjusted based on patient's clinical presentation.

Table 3.2: Switching FROM another OAT Medication TO SROM

To SROM from Bup/nlx	For sublingual, stop bup/nlx immediately. Start initiation of SROM dose within 24 hours of the last dose of bup/nlx. For LAIB, monitor for withdrawal symptoms and treat accordingly.
To SROM from Methadone	Cross-taper approach is preferable. - Replace 10 mg of methadone with 80 mg of SROM (1:8). - Decrease methadone and increase SROM concurrently, every 3 days.

*A future iteration of MHAP OAT Guidelines will include more information about LAIB.

Switching FROM SROM TO another OAT Medication

Clinicians are encouraged to counsel patients on the risk of precipitated withdrawal when rotating from SROM to bup/nlx. See Bup/nlx Section: Risk of Precipitated Withdrawal.

There is a difference in replacement ratios because methadone has a prolonged and variable half-life and regular dosing increases the potency.

Table 3.3: Switching FROM SROM TO another OAT Medication	
From SROM to Bup/Nlx	Micro-dosing / low-dose rotation is preferred. Other bridging strategies used for methadone to bup/nlx can also be applied
From SROM to Methadone	Cross-taper approach is preferable. - Replace 100 mg of SROM with 10 mg of methadone (10:1). - Increase methadone and decrease SROM concurrently, every 3 days.

Ongoing SROM

The goal is to stabilize the once-daily dose at the lowest dose that relieves withdrawal symptoms and suppresses unregulated opioid use. Currently, evidence from published literature is limited to the maximum 36-week duration of clinical trials (BCCSU, 2023 p.159). This guideline supports following stabilization and tapering practices similar to those of methadone and bup/nlx.

Dispensing Frequency

In general, **it is recommended that SROM be prescribed once daily for OUD, with all doses witnessed by pharmacist** to minimize the risk to the patient and community. While DWI of SROM is recommended, **longer dispensing intervals may be considered if the patient shows exceptional and sustained improvements in clinical and social stability.**

This flexibility can help to improve their quality of life, social functioning, and employment, as well as retention in the program. When SROM is dispensed, use clinical judgement and collaborate with the patient and the pharmacist. Consider the value to the patient of having their stability acknowledged. Consider also the limitations of pharmacy access in rural areas.

Although recent guidance out of British Columbia shows more liberal dispensing frequency of SROM, OAT providers in Nova Scotia with experience prescribing SROM recommend more conservative practice based on local context.

Considerations to guide decisions about dispensing frequency (also known as 'stability factors'):

- Verifiable abstinence from substances, including alcohol **(CRITICAL with SROM)**. Potential methods to verify include:
    - POCT UDS or TMS (tandem mass spectrometry)
    - Random breathalyzer samples
    - Lab testing Ethylgluconaride (ETGX), Phosphatideylethanol (PETH), and Ethyl Sulfide
    - Collateral history from HCPs
- Attendance at and engagement during appointments.

- Few missed doses.
- Safe living environment.
- Safe storage of medications.
- Stable mental health.

After a minimum of three (3) months on treatment, a gradual schedule for introducing dispensed doses may be considered for patients who demonstrate exceptional and sustained improvements in clinical and social stability. Begin with one initial dispensed dose and lengthen dispensing by gradually adding dispensed doses that are initially non-consecutive, **up to a maximum of 6 per week.**

The Dispensing Frequency Agreement form (Appendix H) must be reviewed, signed and added to the patient's health record. It is recommended that providers and teams review the OAT Dispensing Frequency Agreement Clinical Resource Guide to ensure discussion with the patient includes:

- The risks associated with dispensed SROM,
- Factors that impact increases or decreases in dispensing frequency,
- The dangers of taking SROM in ways other than as prescribed,
- The dangers of sharing SROM, and
- The importance of safe storage and managing dispensed doses.

SROM must be dispensed in compliance packaging for monitoring. It is strongly recommended that providers indicate this on the prescription. See Appendix B for sample of best practice prescription.

If a patient with unwitnessed dispensed doses begins to demonstrate instability, it is strongly recommended that providers **immediately** reduce dispensing intervals and return to DWI. Any team member can communicate with the dispensing pharmacy team; an adjustment form or new prescription may be needed.

Missed Doses

Missing doses can be an indicator of instability. If a patient is missing doses early in treatment, SROM may not be the best medication to prescribe for them.

Despite delayed absorption, the underlying short morphine half-life results in **the potential for rapid loss of tolerance following missed doses** and the possibility of harmful over-sedation or overdose. To mitigate this, it is recommended that providers and pharmacists work closely together and stay connected regarding missed doses and daily patient assessments.

To avoid overdose that may result from lost tolerance, community pharmacists are required to notify providers of **all** missed doses. When possible, clinicians review DIS profiles. Under current standards, **the dispensing pharmacist will not dose the patient without reassessment after four (4) missed doses, in accordance with clinical practice guidelines.** Pharmacists may prescribe to adapt a prescription to reduce a dose as required in the event of a missed dose or doses in accordance with the established standard of care provided by primary care providers or specialists and aligned with current clinical practice guidelines.

Table 3.4, adapted from META:PHI (Cheema et al., 2023) and (BCCSU, 2023), is a guide to determining next steps after missed doses.

Table 3.4: Missed Doses of SROM	
Consecutive Days Missed	**Dose**
3 (patient presents on Day 4)	Continue previous dose.
4 (patient presents on Day 5)	Cancel prescription. Reassess. Can restart at 50% of previous dose or initiation dose (whichever is higher)
5 (patient presents on Day 6)	Cancel prescription. Reassess. Re-start titration.

In determining dose adjustments after missed doses, clinical judgment is critical, considering:

- Total daily dose
- Number of missed doses
- Possibility of diversion
- Other opioid use during periods of missed dosing
- Type and amounts of opioids used most recently
- Previous experience with SROM treatment.

Monitoring

When prescribing SROM, providers are required to request UDS and medication checks. See Table 3.5 for a recommended schedule. The notification process is the same for all OAT medications.

Medication Checks (Pill Counts)

Random pill counts are required for dispensed SROM. This critical monitoring may be done by the pharmacy (***if*** the community pharmacy has capacity and has agreed). **Dispensing in compliance packaging supports ease and accuracy of pill counting.**

Urine Drug Screens (UDS)

Table 3.5 outlines the recommended UDS Schedule for patients that are prescribed SROM. For more details, see UDS in the Overarching OAT Section.

For people treated with SROM, standard POC tests for opioids will be positive due to morphine and/or glucuronide metabolites (Cheema et al., 2023). See Appendix J: Expected Findings in Mass Spectrometry for more information.

- POC tests for opioids are unable to distinguish morphine from heroin.
- POC tests for hydromorphone may also be positive; hydromorphone is a minor metabolite of morphine, which becomes relevant and can be detected with high morphine doses.
- Laboratory analysis with chromatography-mass spectrometry can be used to distinguish between heroin, codeine, hydromorphone, and morphine.

If clinically indicated to differentiate between the use of hydromorphone, and morphine breakdown into hydromorphone for patients prescribed SROM, samples can be sent to NSH Toxicology Laboratory for mass spectrometry testing to confirm POC UDS results.

Table 3.5: UDS Schedule SROM	
Treatment Stage	**UDS Schedule for Patients Prescribed SROM**
Initial UDS	Not required to diagnose OUD but helps to confirm opioid use. Discussion of results can be useful to build rapport with patient and help reduce risk to the patient, especially given the increased risk during the first couple of weeks of initiating some OAT.
Initiation / Stabilization	Suggest weekly UDS for at least the first month, at the discretion of provider and for purposes of monitoring.
Ongoing	Frequency of scheduled appointments is a team decision, individualized for each patient depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. When possible, it is recommended that UDS be completed at the time of scheduled appointments as a tool for open communication. If the patient is unable to provide a sample, they should still be seen for their appointment.
Dispensed Medication	Random UDS **are required** for dispensed SROM. It is recommended to request an additional six (6) random UDS per year. More frequent UDS should be clinically indicated, and results should not be used in a punitive way. Alternative UDS frequency (i.e., greater frequency) can be determined by team based on individual patient assessment.

Safety

Dispensed SROM must be kept safe as diversion poses a public health risk. SROM becomes accessible within the community when dispensed doses are improperly stored, lost, stolen, shared, traded, or sold.

Decision Support

When making decisions about dispensing frequency, the care provider and the patient being prescribed SROM will discuss the risks of unintentional SROM diversion and ingestion, documenting assurance that medication can be safely stored.

Because treatment with SROM requires diligent measures, care providers with less experience prescribing SROM are encouraged to consult with an Addiction Medicine specialist before starting a patient on SROM.

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Safe Storage

SROM must be dispensed in compliance packaging for monitoring. It is strongly recommended that providers indicate this on the prescription. See Appendix B for sample of best practice prescription.

All persons receiving dispensed doses of SROM **must** store them where others cannot access them.

Missed Random Pill Counts

If a patient is considered to have **missed the random pill count, patient will return to DWI on next pick-up day at pharmacy until contact is made with ORP clinic**. The patient will be asked to return for a clinic appointment and team discussion. Clinicians and providers are encouraged to approach the conversation with non-judgmental curiosity, rather than assuming that doses were diverted, or the individual has destabilized. Next steps will be determined through clinical judgement.

The suggested window to request random monitoring is 48 hours. If a client presents beyond the requested 48-hours, it is recommended to proceed with UDS and medication checks- "late" is not the same as "skipped". The information garnered is still useful, both in terms of the test/audit result, and the effort made to comply. A hard cut-off is seldom beneficial.

If Patient Reports Doses Have Gone Missing:

When the care team decides to replace the missing doses, **new doses must be witnessed daily.**

Prior to returning to the previous dispensing interval, the ORP team will reassess the individual's stability factors with a focus on safe storage of medication.

Repeated incidents of missing doses will result in a team discussion and possible return to witnessed dosing at the community pharmacy.

Tapers

For patients with no acute safety concerns, SROM tapers can be done by no more than 10 percent of the morphine equivalent dose, no more frequently than every two weeks. A slower tapering process may be required once low dosages are reached, and the time interval between doses may be extended.

Drug Shortages

Shortages of SROM of variable duration have occurred over the past number of years. When SROM is unavailable, morphine sulfate extended-release capsules (e.g., M-ESLON) can be alternatively prescribed with twice-daily dosing.

Care must be taken to avoid double-dosing, as morphine sulfate extended-release capsules release morphine over a twelve-hour period rather than a 24-hour period. No adjustments or reductions for differences in opioid tolerance are required (i.e., 200 mg SROM dose can be switched to 100 mg BID M-ESLON). (Cheema et al., 2023)

Providers may request pharmacist to notify them when SROM becomes available again so that a new script can be sent. For example, provider may write on prescription *"M-ESLON 100mg BID for Kadian™ shortage. Witness both doses a minimum of 8 hours apart. Please notify when SROM is available again to update prescription."*

Note: BID witnessed dosing can be cumbersome for patient and not always possible for pharmacy with hours, etc.

Section 4: Key Considerations for Prescribing OAT Medication

The prescribing of OAT requires a comprehensive, patient centered approach to ensure its effectiveness in treating OUD. This section outlines key considerations for OAT prescribing, including the ongoing assessment of progress in treatment, the unique needs of specific populations, and the integration of virtual care to enhance accessibility and patient engagement. By incorporating these key considerations into practice, providers can tailor OAT to meet individual patient needs, improve treatment outcomes and support long term recovery.

Additionally, this section provides guidance on safely discontinuing OAT when appropriate, and recommendations for co-prescribing medications to optimize therapeutic outcomes. Patients are encouraged to attend a primary care provider or team for other healthcare needs. ORP teams members / OAT providers are encouraged to communicate openly and regularly with the patient's care providers.

While addiction medicine teams across the province may be resourced differently, MHAP supports efforts to treat the whole person, where capacity allows, and within the provider's scope of practice, recognizing the importance of holistic medical care in the journey to recovery.

Assessing OAT Progress

Ongoing evaluation of progress toward the patient's identified goals is critical to ensuring that treatment remains effective, safe, accountable, and responsive to the patient's dynamic needs.
Regular assessment:

- Allows providers to monitor for improvements in key areas such as reduction in substance use, stabilization of physical and mental health, and increased engagement in health services.
- Helps to identify potential complications or side effects early, enabling timely interventions to prevent harm.

Measurement Based Care (MBC) is a clinical process in which clinicians and clients use regularly collected client-reported outcome measure data to track progress and to inform treatment decisions. MBC empowers clinicians and clients by improving communication and collaboration. Lack of symptom improvement or progress towards goals is more rapidly detected using MBC, which allows for quicker adjustments to treatment thus contributing to better client outcomes. When possible, leverage outcome measures from validated clinical tools throughout treatment, informing clinical decision making, increasing engagement, and improving outcomes.

Indications the Patient is Benefitting from OAT

Clinical Benefits

- Reduced (or cessation of) illicit substance use.
- Reduced risk and incidence of substance use medical emergency due to reduction or cessation of illicit opioid use.
- Reduced cravings.
- Reduced acquisition of blood borne pathogens.

- Reduced incidence of skin, soft tissue and more serious bacterial infections, including sepsis.
- Reduced healthcare utilization, including emergency services and hospitalization.
- Increased engagement in primary care and other health services.
- Management of withdrawal symptoms.
- Patient report of improved overall quality of life.
- Medication and treatment adherence.
- Patient engagement in treatment.

Psychosocial Benefits

- Reduced need to engage in high-risk and criminalized activities to support substance use.
- Stabilizing income.
- Finding purpose in life.
- Improved self-esteem.
- Integrating new activities.
- Reconnecting /repairing relationships with supportive family and friends (e.g., improved social functioning).
- Attaining and maintaining safe, adequate housing and accessing other social services that meet their needs.

Indications the Patient May Not be Benefitting from OAT

- No change or increased intensity of illicit substance use.
- No change or increased risk of substance use medical emergency.
- Urine drug screens are consistently negative for prescribed medication.
- No change in wellbeing or social functioning.
- Consistently missing doses.
- Development or worsening of mental or physical health conditions.

Ongoing cravings and withdrawal symptoms may be signs of inadequate treatment. If a patient is not benefiting, or perceiving benefit, from their current care plan, adjustments can be made to the type of medication, dosage, psychosocial interventions, and/or additional supports, to optimize treatment outcomes. This dynamic approach ensures that OAT is personalized and responsive, supporting quality of life for the patient.

Tapering OAT

OUD is a chronic medical condition that benefits from long-term and open-ended treatment. No recommendations exist to indicate an optimal treatment duration. It is recommended and encouraged that OAT treatment continue for as long as desired by the patient to provide stability, functionality, and reduce harms.

For some individuals, the duration of treatment is an important question. Since OAT programs are intensive and demand a large commitment from the patient, it is not uncommon for patients to request to withdraw from treatment.

It is vital to understand what is driving the patient's desire to stop treatment. Some concerns may be amenable to medical management (e.g., side-effects, re-evaluation of dispensing intervals), education, and/or reassurance. Providers may want to ask about barriers to continuing with treatment, such as finances, difficulties with transportation, family responsibilities, and work schedules. **Explore any**

misconceptions related to discontinuing OAT. Patients may be subject to stigma and judgements from family or friends, employers, or even other care providers. These concerns must be explored in a sensitive manner.

Provider Considerations

- Individuals who discontinue OAT are at increased risk of returning to opioid use and related harms including drug toxicity death. Providers will discuss these risks with patients and advise ongoing engagement in treatment.
- Patients who wish to discontinue OAT will be advised to consider a gradual taper that extends for as long as necessary to be well tolerated.
- Evidence suggests that a longer time on OAT prior to initiating the taper (>52 weeks vs. <12 weeks) shows higher rates of successful taper and lower risk of subsequent opioid toxicity (BC Centre for Substance Use and Addictions, 2023).
- If a patient has been taking their prescribed medication, abrupt OAT termination will lead to opioid withdrawal.

To facilitate discussion with patient, see Appendix K: Tapering Readiness Questionnaire.

For additional support, consider consulting with an Addiction Medicine specialist. The Addiction Medicine Consult Service (AMCS) is available Monday to Friday 8:30 am to 4:30 pm, offering rapid telephone advice to physicians, pharmacists and nurse practitioners: 1-855-970-0234.

Client-driven Tapers

If a patient wishes to discontinue OAT medication, a slow and gradual taper will be offered. Gradual tapering over months to years is preferred for safety and stability reasons. If patient requests a more rapid taper, providers are encouraged to clearly explain the risks in a compassionate and non-judgmental way while maintaining client engagement. Ideally, the prescriber and the patient agree to a taper schedule and pace, however there is no obligation on the part of the provider to prescribe an unreasonably short taper that is likely to be poorly tolerated.

Provider and patient will co-create a plan with balanced decision-making, being mindful of the evidence showing added benefit with longer treatment. The duration and rate of dose reductions will be adjusted on an ongoing basis, based on clinical response to dose changes, as well as patient goals and preferences to better support re-engagement in the future, should the need arise.

When possible, an interdisciplinary team approach will be used during the tapering process to support complementary non-pharmacological and pharmacological management. Additional wraparound supports might include relapse prevention planning, referral to Recovery Support Centres and/or Community Mental Health and Addictions. Ensure patients have ORP clinic contact information and are aware they can reconnect for services at any time.

Clinic-driven Tapers

Clinic-driven tapers are a last resort and undertaken only for clear reasons of safety. If a breakdown in care occurs between the patient and the care team, key steps should include team discussion (including ORP manager), consensus and documentation of clinical reasoning that outlines a weighing of the risks. If

determined OAT care can no longer be safely provided by the clinic, every effort to connect the patient with another OAT provider will be made. When unable to refer to another provider, follow the tapering guidance in the specific medication sections.

These situations present significant risks, so the ORP team (including the provider) must make every effort to mitigate the risks by:

- Facilitating transfer to other care providers where appropriate and possible,
- Offering harm reduction education, sterile supplies and take-home naloxone,
- Ensuring patients are aware of emergency mental health options (e.g., crisis line, Emergency Department).
- Notifying providers in the circle of care and individuals in the circle of support, with patient consent.

MHAP ORP does not condone the practice of clinic-driven discharge where a patient is denied ongoing treatment due to substance use. Abstinence-based models of care have been identified as undermining treatment outcomes for people with substance use disorders (SUD) (Gallant et al., 2024).

The program manager may also want to consider consulting with the zonal director, other ORP managers, and colleagues in legal/risk management, occupational health and safety, and ethics to ensure all options have been considered.

Contingency Planning for OAT

Contingency planning is a critical component of safe and effective OAT. This may involve arranging short-term dose adjustments, bridging prescriptions, and communication with other health care providers. Contingency planning must be documented, communicated to the patient, and reviewed regularly to ensure it remains appropriate and responsive to changing needs.

In the event of a disaster or emergency such as extreme weather events, public health crises, infrastructure disruptions, prioritization will be given to patient safety and access to OAT medication including emergency dose supplies, rapid communication with patients and providers, coordination between pharmacies and clinics. Some details in the plan may need to change, in collaboration with ORP staff, community pharmacies, and patients.

Considerations when Prescribing for Travel

MHAP ORP Client Travel or Relocation

When determining whether to maintain or transfer care, the team should consider factors such as the anticipated duration of relocation, the client's overall stability, and the receiving clinic's capacity to provide ongoing monitoring. Providers and ORP staff are encouraged to have supportive conversations with the client about the purpose of their travel, and discuss how to help them reach their goals.

All communication between care teams should be documented to ensure shared understanding of the plan. Clients should be informed of the agreed-upon care approach and provided with contact information for both the originating and receiving clinics.

Within Nova Scotia

When a patient enrolled in ORP relocates temporarily or permanently within the province (e.g., to another zone or community with a different ORP clinic), care coordination must ensure uninterrupted and safe continuity of treatment.

When a client temporarily relocates or travels within the province, there are two primary options for managing ongoing OAT care.

- Original Clinic Maintains Care

  In some cases, the originating ORP care team may continue to oversee OAT management while the client is away. The local ORP or RSC clinic in the client's temporary location may assist by providing on-site monitoring and communicating any clinical concerns back to the originating team. The originating care team remains responsible for prescribing, follow-up, and all clinical decision-making. Clear documentation outlining shared responsibilities between the two clinics must be entered in the client's chart to ensure alignment.

- Transfer of Care to a New Location

  If the client's stay is expected to be prolonged or indefinite, a formal transfer of care may be more appropriate. In these cases, a *Transfer of Care (TOC) / Complementary Service Form* must be completed and sent to the receiving clinic. The receiving team assumes full responsibility for the client's ongoing care, including assessment, prescribing, and follow-up. The referring and receiving teams must confirm key details, including the effective transfer date, the next scheduled appointment, and the date of the last prescription issued by the originating team.

Out-of-Province Travel

- Confirm whether a pharmacy is available at the travel destination to provide OAT doses while the client is away.
- Confirm whether a provider/clinic in the area is available to temporarily provide care and monitoring.
- If needed, verify whether the travel destination can legally accept Nova Scotia prescriptions for monitored drugs.
- Consider potential travel interruptions or delays when determining the length of the prescription.
- Review government restrictions, resources for requirements, and/or recommendations regarding travel with prescribed narcotics.
- Provide documentation outlining rationale for the prescription, the intended recipient, and any relevant instructions.

For non-MHAP clients requesting travel dosing from MHAP ORP

Occasionally, individuals who are not connected to ORP or a Nova Scotia provider, may require temporary OAT dosing while visiting or residing in the province. The goal of temporary dosing is to prevent treatment interruption and reduce risk of withdrawal, relapse, or harm to the patient.

To safely support temporary dosing, a release of information must be completed to allow communication with the patient's current prescriber and pharmacy. This ensures that verification of the patient's current treatment and dose can be confirmed.

Additional considerations include:

- ORP clinic staff are to help facilitate a smooth temporary transition of care. While prescriptions can be rewritten by a pharmacist, it is recommended that ORP collaborate on this whenever possible.
- Clear communication around expectations with clients and between providers and pharmacists, and ensuring documentation is complete.
- Depending on length of time temporary dosing is required pharmacists can provide bridging prescriptions.
- If the client needs shift from temporary travel dosing to permanent care, review what documentation pieces need to be completed.

Note: If client is coming from out of province, non-NS providers can register with NSPMP and gain authorization to write OAT prescriptions for NS. This is the least disruptive to client care, however it does take a couple of days to arrange.

Virtual Care

Providers and team members are encouraged to help the patient reduce the barrier(s) to being seen in person. In some cases, virtual care may be an option, especially when leveraging the partnership with pharmacies.

Virtual appointments are most effective when supported by regular in-person check-ins with the patient's pharmacist and/or other ORP team members. Especially in rural areas, providers might consider alternating short virtual/phone appointments with in-person provider appointments. For providers who support multiple clinics, someone else from the clinical team could be with the patient in person, while the provider is virtual.

NS Health has a Virtual Care Policy and endorsed best-practice principles and guidelines for virtual care. These guiding principles provide a basis for providers to determine when virtual care might be appropriate. Providers can use these principles to document the rationale for using virtual care or deciding not to use this approach. The documented rationale would be repeated when decisions around care provision change, e.g., if a patient's clinical stability decreases, the provider could document that as the rationale for discontinuing virtual care, in the interest of optimizing therapeutic rapport and more robust monitoring.

Note: For patients without reliable access to a device/internet connection, virtual care will be a challenge. Where possible, patients can be supported to obtain access to a device and necessary connectivity e.g., at another MHAP site or public library.

Populations Requiring Special Consideration

The recommendations outlined in this guideline are intended to be applicable and relevant to the general adult patient population. However, there are additional factors to consider, as some individuals and communities may experience added complexity due to biological, societal, or resource-related factors. Keeping diversity and patient context front of mind will help ensure a successful application of these guidelines to diverse client populations. A brief overview of additional considerations is offered below.

This section is not meant to provide detailed clinical practice guidance for managing OUD in these populations, but rather to offer an overview of key considerations for fostering positive partnerships and delivering patient-centered, safe and effective care.

Clinical Complexity

This section offers general, high-level guidance for supporting patients with clinical complexity; however, this does not address all potential clinically complex situations. For case-specific consultation or additional support, please reach out to AMCS.

Concurrent Disorders (CD)

To support effective integrated care for individuals with concurrent substance use and mental health disorders, best practice is to use an integrated and collaborative care model wherein the level of care is dependent on the severity of each disorder.

Best practice for patients who present with opioid use disorder (OUD) is to screen for:

- Concurrent mental health disorders (e.g., anxiety, depression, post-traumatic stress disorder (PTSD), personality disorders, ADHD).
- Suicide risk.
- Trauma and abuse (past or current).
- Intimate partner violence.

ORP patients who have a co-occurring mental health concern are to be offered a referral for an appointment with an outpatient Community Mental Health and Addictions clinic for further assessment and evidence-based treatment. To avoid fragmentation and ensure integrated care, both care teams will collaborate on the creation of a care plan. ORP strives to include treatment of identified concurrent disorders beginning while referral is in process.

For ORP patients with CD who are hospitalized, promote seamless transitions and coordinated care between the inpatient unit and the ORP clinic to prevent service fragmentation.

While concurrent treatment is recommended, stabilization on OUD treatment- including initiation of OAT – is a priority for patients with severe OUD. This ensures that a person's physiological needs are being met to enable the engagement required to clarify, diagnose, and treat any co-occurring disorder.

To prevent, monitor and manage drug interactions between OAT and other prescription or non-prescription medications a patient may be taking, collaboration with pharmacists is recommended. **Methadone and SROM interactions require particular attention.**

Prescribed benzodiazepines :

Avoid co-prescribing benzodiazepines (BZRAs) to patients on OAT due to increased risk of respiratory depression, daytime hypersomnolence, cognitive disturbance and drug toxicity deaths.

Evaluate the indication for OAT patients who are already on long-term BZRAs (i.e. legacy prescribing). Tapering will be recommended routinely due to the associated risks and lack of long-term indication.

Continued BZRA prescribing in individuals receiving OAT should prompt active discussion and a structured taper plan. Engage patients in conversations about tapering using motivational, trauma-informed, and collaborative approaches. Tapering is particularly important if the patient:

- Has respiratory disease or sleep-disordered breathing,
- Is not adhering to monitoring requirements,
- Is an older adult, or
- If they are taking:
    - multiple daily doses.
    - A full mu agonist.
    - other medications or substances with sedating properties.

Prescribed stimulants:

When capacity allows, ORP providers may undertake screening for and diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD). Screening may include:

- Obtain collateral information e.g., family or caregivers, previous records including old school report cards and/or someone who can provide information on the identified behaviors in childhood. ADHD has an onset in childhood and can be ruled out if symptoms did not exist before age 12.
- Symptom assessment tools e.g., Adult ADHD Self-Report Scale (ASRS)
- Differential diagnosis
    - Consider contributing factors, such as withdrawal, poor sleep, other active substance use. If possible, wait until substance use has stabilized to gain clarity on whether it has been causing symptoms.
    - Screen also for comorbid conditions with overlapping symptoms, e.g. anxiety, mood and psychotic disorders

Formulations that are prodrugs, e.g., lisdexamfetamine, are preferred as they have no effect until they undergo first pass metabolism. In adults with concurrent ADHD and OUD, long-half life or slow-release formulations are preferable as they maximize treatment adherence and minimize risk. Psychostimulants are most effective however they come with the greatest potential for adverse effects, including affecting QTc intervals posing risk of arrythmias.

Best practice to manage ADHD involves psychological interventions and pharmacotherapy. Up to 20% of patients may not have a clinically significant response to medication alone, underscoring the importance of a comprehensive multi-modal approach. Prescribers should routinely monitor the efficacy, tolerability, and ongoing need for stimulant medication. As with other OAT medications, structured monitoring and follow up is recommended to support individual and community safety. Consider including stimulant medication monitoring with routine OAT medication checks.

Managing Acute / Chronic Pain

Patients receiving Opioid Agonist Therapy (OAT) may experience acute or chronic pain that requires thoughtful, coordinated management. The goals of care are to ensure effective pain control while maintaining stability in OAT and minimizing the risk.

Key Principles

- Maintain OAT continuity: Continue the patient's regular OAT dose during episodes of acute or chronic pain. Abrupt dose reduction or discontinuation can worsen pain sensitivity and increase relapse risk.
- Assess pain comprehensively: Evaluate the nature, severity, and contributing factors of pain, including psychological and social dimensions. Due consideration must be given to investigating the source of the symptoms and the possible underlying cause(s).
- Use multimodal strategies: Optimize non-opioid pharmacologic options (e.g., acetaminophen, NSAIDs, block procedures, etc.) and non-pharmacologic approaches such as physiotherapy, mindfulness, pain reprocessing therapy, or cognitive-behavioral interventions.
- Coordinate care: Collaborate across settings — including primary care, pain management, and addiction medicine — to ensure consistent messaging and avoid fragmented prescribing.
- Adjust doses safely when needed: For acute pain, short-term additional opioid analgesia may be required; dosing should be individualized, recognizing tolerance and cross-coverage needs. For chronic pain, titrate gradually with frequent reassessment.
- Monitor and communicate: Maintain clear documentation and communication among all treating providers. Review prescription monitoring data and involve the patient in all decision-making.

Acute Pain

Adequate pain management is vitally important to successful inpatient care. Given the lack of evidence supporting improved outcomes with the discontinuation of OAT in the context of acute pain, and the high mortality risk associated with untreated opioid use disorder, OAT should not be routinely discontinued in the context of acute pain or surgery. The primary recommendation is to continue buprenorphine treatment in the perioperative period.

Available evidence and guidance indicate that patients' OAT dose should be continued. **The baseline OAT dose will not address acute pain.** When opioids would normally be indicated for the treatment of an acute medical condition, opioids should still be given to a person actively receiving OAT and may need a higher dose because of the development of tolerance. Non-opioid adjuncts (e.g., ibuprofen, acetaminophen) may be considered for pain control.

In situations where more than one opioid is prescribed, a rough timeframe of acute pain treatment should be reviewed with the patient in advance. The timeframe may vary depending on the underlying condition or surgical procedure involved, from a few days to a few weeks. Pain ceases to be acute when it has reached six weeks in duration, at which point a different plan will be implemented.

Chronic Pain

Patients presenting with chronic pain should have access to additional services for pain management. Nova Scotia Health offers Chronic Pain Services through the Pain Management Unit and its satellite clinics, as well as the Pain Self-Management Program. Information about these services can be found at Nova Scotia Health Library Services Guide for Chronic Pain.

Polysubstance Use

OAT medication is safe and effective in the setting of polysubstance use and may help to stabilize the use of substances other than opioids. Polysubstance use is not a reason to suspend OAT but may be an indication to modify treatment accordingly. Regularly assess patients for alcohol, nicotine and other substance use, and offer appropriate psychoeducation and treatment.

Possible treatment modifications may include OAT medication dose adjustment, transitioning to another OAT medication, or increasing psychosocial and other supports. In such cases, harm reduction and overdose prevention measures are to be discussed and reinforced.

Patients will be advised of the risk of overdose due to contamination of the unregulated drug supply, including fentanyl and other highly potent synthetic opioids (including non-opioid substances such as benzodiazepines, stimulants, and xylazine) and receive information and/or education on harm reduction strategies and resources, including but not limited to:

- Safer using strategies.
- Take-home naloxone.
- Sterile drug use supplies.
- Supervised consumption services.
- Drug Harms Alert Service for Nova Scotia
  - To sign up to receive alerts, email NSDrugAlert@nshealth.ca
- If using substances alone:
  - National Overdose Response Service (NORS): 1-888-688-NORS (6677) call or text.

Psychosocial treatments, interventions, and supports are offered as adjunct treatments to OAT to increase treatment retention. Additional services within Nova Scotia Health offering support to patients experiencing substance use disorders include:

- Community Mental Health and Addictions – i.e., psychotherapy
- Recovery Support Centres – i.e., psychoeducation, outpatient withdrawal management
- Inpatient Withdrawal Management (IWM).

Stimulants

If patients are using stimulants (e.g., cocaine or methamphetamine) while receiving OAT, consider increasing psychosocial interventions and supports. In some cases, it may be beneficial to consider combining OAT with outpatient treatment, which will facilitate the close monitoring and the incorporation of clinical interventions to reduce stimulant use (e.g., Contingency Management, Community Reinforcement Approach, Cognitive Behavioural Therapy (CBT)).

For more information on treatment options for stimulant use disorder, see the BCCSU's Stimulant Use Disorder Practice Update .

Cannabis

Although cannabis withdrawal is common when reducing or ceasing use, there are no agreed upon evidence-based pharmacotherapeutic approaches to managing withdrawal symptoms or reducing ongoing use for cannabis use disorder (CUD). This is due to the long half-life of cannabis. Moreso, withdrawal symptoms are not as intense compared to some of the other substances. There are no medications approved for use as pharmacotherapy treatment options for CUD.

Patients who are using cannabis may benefit from a discussion of the recommendations made in the Lower-Risk Cannabis Use Guidelines (Canada, 2020).

Sedatives

Ongoing sedative use, including z-drugs, increases risk and should factor in decisions about prescribing, dispensing, monitoring and clinical assessment frequency.

Alcohol

Withdrawal from alcohol use, or alcohol intoxication while taking OAT medication, can be life threatening. Clinicians supporting individuals who use alcohol must remain attentive to signs that warrant medical assessment. Symptoms of alcohol withdrawal can vary depending on several factors, including the amount and duration of alcohol use. To explore outpatient or inpatient withdrawal management options, connect with your local Recovery Support Centre.

Current research supports the use of contingency management in the treatment of alcohol use disorder (AUD). Several other psychological interventions for AUD have significant empirical support in their use, including MI and CBT. For individuals on OAT who meet criteria for high-risk drinking, brief intervention has been found to reduce alcohol consumption .

Although OAT prescribing in individuals with co-occurring AUD requires caution (i.e. naltrexone is contraindicated when a patient is opioid dependent), unregulated opioid use presents a significantly higher risk of harm. For more information on treating individuals with co-occurring AUD and OUD, please see the BCCSU's Managing Co-occurring Opioid Use and Alcohol Use Disorders bulletin .

For patients diagnosed with **co-occurring AUD and OUD**, AUD pharmacotherapy should be offered with consideration of drug-to-drug interactions with OAT, as applicable. Many pharmacotherapy options exist to support alcohol treatment goals, including medications to reduce cravings, as well as medications to manage withdrawal symptoms.

Medications for AUD:

1. **Acamprosate** can be considered along with evidence-based psychosocial treatment interventions and supports for treating concurrent AUD. Acamprosate has an established evidence base for safety and efficacy for the treatment of AUD and does not pose significant safety risks when used concurrently with CNS depressants.
2. **Topiramate** may be considered for the treatment of AUD in patients who are also on OAT in cases *where acamprosate is not appropriate*. Topiramate has not been well studied for the treatment of AUD in patients with concurrent OUD; however, the efficacy of this medication for the management of AUD is supported by an established body of evidence, and it is not contraindicated for patients who use CNS depressants concurrently.
3. Use caution when considering **gabapentin** for AUD treatment for a patient on OAT. Although gabapentin has a growing evidence base supporting its use for withdrawal management and preliminary evidence supporting its use in relapse prevention for AUD, this medication may heighten the euphoric effects of opioids and increase the risk of respiratory depression and overdose if used at moderate-to-high doses concurrently with opioids. Providers must be aware of these risks when co-prescribing, monitoring, and determining the frequency of clinical assessment.

Non-prescribed Benzodiazepines

Co-occurring use of benzodiazepine receptor agonists (BZRAs; benzodiazepines and z-drugs) and opioids significantly increases the risk of respiratory depression, overdose, and death. When prescribing OAT, **all patients are to receive education on the risks of combining opioids and BZRAs.**

Clients with regular and high dose use of benzodiazepines may be at risk for complicated sequelae of withdrawal. The risk differs based on the level and frequency of use and also varies by different compounds with the danger being greater with some specific drugs, and generally greater with shorter-acting benzodiazepines compared to longer-acting ones. Abrupt cessation is generally not recommended.

Clients should follow a controlled taper plan for reduction of consumption rather than abrupt discontinuation of benzodiazepines. During a BZRA taper, consider dispensing BZRAs at the same frequency as OAT medications.

A personal history is the most predictive factor for complicated benzodiazepine withdrawal. If a client reports having seizures or delirium with cessation of use in the past, and has abruptly halted use, that individual should be referred for medical monitoring and management of withdrawal.

Benzodiazepines are included in ORP urine drug screens however, clinicians are to be aware that some benzodiazepines and benzodiazepine analogues (e.g., alprazolam, clonazepam, etizolam, temazepam, triazolam) may not be detected in standard urine drug screens despite the patient having been exposed.

Due to the high risk of overdose death associated with unregulated opioid use, it is not advised to delay or withhold OAT for patients who use benzodiazepines or if benzodiazepine exposure through the unregulated drug supply is suspected. However, patients are not to be started on OAT while sedated. Providers are recommended to collaborate with the community pharmacist and/or with the AMCS

Life Stages

Youth

While this guideline is intended to be applicable to all adults aged 19+, there are unique considerations for adolescents (age 12-17) and young adults (18-25), collectively referred to as “youth” in this document.

Some practitioners may be hesitant to prescribe OAT to youth, due to reluctance to start them on what is frequently considered a long-term treatment, as well as concern over bringing youth into daily contact with adult patients (if youth-specific OAT services are not available). These concerns are to be carefully weighed against the risks of discontinuing or not starting pharmacotherapy and continued drug use including overdose, HIV, viral hepatitis, and other morbidity and mortality factors.

Whenever possible, providers should have experience working with this population and should collaborate with youth clinicians. If you do not have the knowledge, skills or resources to treat adolescents with OUD, consult an experienced colleague to assist with assessing appropriateness of OAT. Consultation may be sought from the IWK Concurrent Disorders Specialty Care Clinic.

While evidence is limited related to bup/nlx treatment in youth:

- Buprenorphine used as analgesia has been shown to be safe and effective in adolescents.
- An evaluation of adolescents aged 15-18 receiving bup/nlx for OUD found it to be well-tolerated by most.
- Bup/nlx is effective in reducing opioid use in young adults aged 18-25, although reported retention rates are notably lower than those observed in older adults.

Encourage and facilitate engagement in non-pharmacological treatment (e.g., recovery-oriented services) to complement OAT.

Pregnancy

This section offers general, high-level guidance for supporting pregnant patients; however, this does not address all potential clinically complex situations. For more detailed information on prescribing OAT medication during pregnancy, please see the IWK Continuum of Care for Pregnant Persons Diagnosed with Opioid Use Disorder: Comprehensive Summary and Clinical Toolkit. For case-specific consultation or additional support, please reach out to the AMCS or IWK.

Pregnant individuals with opioid use disorder should be offered Opioid Agonist Treatment (OAT) as the standard of care. Continuation or initiation of OAT during pregnancy is associated with improved maternal stability, reduced risk of relapse and overdose, and better neonatal outcomes compared to withdrawal or untreated opioid use. Untreated OUD during pregnancy is associated with numerous adverse outcomes, including fetal growth restriction, fetal demise, and neonatal abstinence syndrome (NAS).

- Withdrawal from opioids is not recommended as an option in pregnancy.
    - If a client-driven taper is requested during pregnancy, consult the AMCS for guidance.
- The risks and benefits of transitioning from one OAT medication to another must be carefully considered under the guidance of a specialist and discussed with the patient and their family (if appropriate).
- Long-Acting Injectable Buprenorphine (LAIB) is not recommended in pregnancy
- Methadone is safe in breast(chest) feeding regardless of maternal dose. Buprenorphine is also considered relatively safe in breastfeeding. Encourage birthparents to take the dose after a feed or pumping session.
- Given the increased potential for ongoing emesis during pregnancy, it is important to understand the **recommendations for maintaining methadone dosing, should a patient vomit the dose**:
    - IF the emesis has been witnessed by a healthcare provider and occurred within 15 minutes of the observed dose, offer one replacement dose of methadone (replacement dose = 50 percent of the regular dose)
    - Serious consideration should also be given to replacing doses where emesis has not been witnessed due to the risk to mother and fetus related to withdrawal.
    - Should the patient continue to have frequent episodes of emesis, healthcare providers may wish to:
        - Reduce the volume of liquid that the methadone is mixed in, and/or
        - Consider spreading ingestion of the dose over 30 minutes with observation at the pharmacy for 15-20 minutes following the dose.

Based on current evidence, health care providers can safely prescribe bup/nlx in pregnancy. **Switching patients to a buprenorphine-only product is not necessary**. Pregnancy was removed as a contraindication in the Health Canada-approved bup/nlx product monograph (Indivior UK Limited, 2021). Due to its superior safety profile, bup/nlx may be especially advantageous compared to methadone in locations where access to specialized care, including daily dispensing requirements for methadone, is limited. **LAIB, however, is contraindicated for individuals who are pregnant. If patient conceives while on LAIB, switch to bup/nlx and counsel around potential risks.**

Bup/nlx dosing principles for pregnant individuals do not differ from the general adult patient population (i.e., individually titrated doses that eliminate or sufficiently reduce withdrawal symptoms). Manage opioid withdrawal symptoms by increasing the dose of bup/nlx and/or administering in split doses until the postpartum period. Pregnant individuals who seek treatment are often prescribed pharmacological interventions that are insufficient in dose and/or duration. Health care providers who are not experienced in treating OUD during pregnancy should consult an addiction medicine specialist.

Further recommendations include:

- Consider dispensed doses of methadone for split dosing even in pregnant patients who may not otherwise be offered them if improved neonatal outcomes and reduced illicit substance during pregnancy justify the potential risks of dispensed dosing.
- Ensure adequate analgesia (opioid and maximized non-opioid pharmacotherapies) during delivery, in addition to any OAT prescribed for baseline needs.
- Monitor patients closely postpartum for the need to adjust the OAT dose, specifically, the need to reduce the dose related to sedation.

Older Adults

While this guideline is intended to be applicable to adults aged 19+, there are unique considerations for older adults (age 65 and above). For specific guidance on prevention, screening, assessment, and treatment of OUD in older adults, as well as an overview of the issues unique to this population, please refer to the Canadian Guidelines on Opioid Use Disorder Among Older Adults (Rieb et al., 2019).

Some recommendations include:

- Offer medications for OUD in the context of connection to long-term addiction, mental health, and primary care treatment, where careful monitoring and dose titration can occur.
- Ensure patients understand the use of alcohol, benzodiazepines, and other sedative-hypnotics is hazardous when combined with OAT.
    - If the older adult is living in the community and is already physiologically dependent on one of these substances, then slow tapering of the substance(s) (to elimination if possible) rather than abrupt cessation is recommended.
    - If the patient is in hospital, inpatient treatment, or a long-term care setting and medically managed by an experienced provider, detoxification can progress more rapidly, concurrent with the initiation or stabilization on medications for OUD.

Equity, Diversity, Inclusion, Reconciliation & Accessibility

Specific populations face unique challenges because of social prejudice and discrimination, internalized stigma, and lack of health care provider competencies specific to these groups. Nova Scotia Health is dedicated to creating a welcoming, inclusive, and equitable environment for both our employees and the people we serve. We are committed to fostering a workplace and health care system where individuals of all backgrounds, communities, and abilities feel represented, respected, and supported.

Through the values of equity, diversity, inclusion, reconciliation, and accessibility (EDIRA), we aim to remove barriers that limit equitable work practices for our employees, while also ensuring patients can access the care they need. By embedding EDIRA principles into our policies, practices, and partnerships,

we are committed to reducing health disparities, honouring Indigenous communities, and supporting a healthier, more inclusive future for all Nova Scotians.

To deliver relevant, high quality mental health and substance use services, it is highly recommended that the clinician learns *from the client* about their cultural background, their understanding of their mental health and substance use concerns, and what constitutes safety from the individual's perspective. This includes accommodating the client's preferred language, accessibility/physical ability needs, and/or needs related to neurodivergence.

> "To help us provide care that feels respectful and meaningful to you, I'd like to ask a few questions about your background and any cultural or spiritual preferences you'd like us to be aware of."

Diversity factors such as cultural or ethnic background, physical ability, socio-economic status, physical co-morbidities, neurodiversity, age, sex, gender, and sexual orientation intersect with the experience with SUDs. The clinician should make effort to become aware of any stressors that may affect or exacerbate the SUD and/or potentially impact the client's response to treatment.

Cultural safety is the creation of a health care environment where individuals or groups feel respected and safe, recognizing and addressing the power imbalances inherent in the relationship between service providers and users, and ensuring freedom from racism and discrimination. This includes equitable service for people who are or feel marginalized, oppressed, and/or underserved because of their identities.

Being culturally responsive is critical to offering safe and inclusive health care. Health providers are encouraged to consider their own inherent biases and worldviews and reflect upon how these may impact the way they perceive and interact with others. **OAT providers and ORP team members are encouraged to participate in education and training that enhances their perspective on cultural humility.**

NS Health's Learning Management System (LMS) and Provincial Centre for Training, Education and Learning (PCTEL) offer several options. **E.g.:**

- PCTEL: *Fundamentals of Cultural Safety for Racialized Populations for Mental Health Professionals*
- LMS: *Equity, Diversity and Inclusion (course code 1183.01)*; *2SLGBTQIA+ Safer Spaces of Belonging (course code 0841.02).*

NS Health, including ORP teams, aim to recognize the contributions of all people with disabilities. The goal is to provide barrier-free experiences for all Nova Scotians. We are committed to people with disabilities taking part in their health care by collaboratively identifying, removing, and preventing barriers, improving accessibility, and providing choice and opportunity.

Social And Structural Determinants of Health

Individuals Experiencing Insecure Housing

Individuals experiencing insecure housing face barriers to accessing and maintaining OAT. Barriers may include difficulties with accessing healthcare, lack of awareness about care options, absence of ID, limited transportation, lack of childcare, inability to safely store medications, and experiences or fear of discrimination in healthcare settings. Clinic appointments and pharmacy visits for OAT medications further complicate access.

Providers can better support this population by collaborating on personalized treatment plans, offering flexible appointments, adjusting medication dispensing as appropriate (including considering dispensed dosing for stable patients), and connecting patients to essential resources like housing, food, financial assistance, employment, and other social services.

Individuals Living or Working in Rural / Remote Areas

Several strategies have been identified for the provision of effective OUD care to individuals in rural and remote settings, including those who work remotely for long periods of time. Higher retention rates on OAT are attributable to increased acceptability and convenience when patients can remain in their communities to initiate and be maintained on OAT.

Health care providers can determine how to adapt the recommendations in this guideline to reduce barriers for patients. For example:

- Utilize Virtual Care to consult with patients, eliminating the need for patients to travel.
- Flexible dispensing frequency where daily visits to pharmacy are not feasible e.g., when the only available pharmacy is not open daily, has limited hours or capacity to do OAT medication dispensing.
- Bup/nlx is a flexible option when daily witnessed ingestion of methadone or SROM at a pharmacy is not practical.
- Consider LAIB to reduce barriers to care and increase treatment retention.

All adaptations to the recommendations should involve team discussion and consensus, and must have a clear rationale, take patient and community safety into consideration, and be well documented.

Individuals Transitioning Into and Out of Carceral Settings

Specific guidance for the treatment of OUD in carceral settings is beyond the scope of this guideline. However, health care providers must be aware of the importance of maintaining OAT care for patients who transition into and out of carceral settings.

Whenever possible, the patient's ORP clinic will collaborate with the provider working in the correctional facility and with the community pharmacist, if applicable, to ensure continuity of care before (and at the time of) release. For contact information for MHAP's Correction Health Services facilities, see Appendix M.

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Appendix A – Decision Support Tool for Selecting OAT

	Buprenorphine-based Formulas		Methadone	SROM
	Buprenorphine/ Naloxone (bup/nlx)	Long-Acting Injectable Bup (LAIB)		
Retention in Treatment	May be slightly lower than methadone; retention improves at higher does (above 16 mg).	Substantially higher than placebo.	Potentially slightly better treatment retention than buprenorphine/ naloxone.	Non-inferior to methadone.
Initiation				
Requires withdrawal prior to initiation	**Traditional initiation:** Yes. Requires moderate withdrawal prior to induction. **Micro-dosing / Low-dose initiation:** No. Does not require prior withdrawal, allowing for comfortable start.	No. Does not require a period of withdrawal, but does require at least 1-day prior stabilization on sublingual buprenorphine/ naloxone.	No. Does not require a period of withdrawal. May be easier to initiate.	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration.
Time to achieve therapeutic dose	**Traditional initiation:** (1-3 days) Shorter time to achieve therapeutic dose. **Micro-dosing / Low-dose initiation:** (5-10 days) Takes longer to reach therapeutic dose.	Two months on 300mg injections, followed by 100 mg maintenance dose.	(May take weeks) Longer time to achieve therapeutic dose.	1-2 weeks
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on sublingual bup/nlx prior to initiation.	N/A	N/A

	Buprenorphine-based Formulas		Methadone	SROM
	Buprenorphine/ naloxone	Long-Acting Injectable Bup (LAIB)		
Side Effects				
Side effects	Milder side effects profile	Medication adverse effects are similar to buprenorphine/ Naloxone. Injection site pain and pruritus.	More severe dose-dependent side effect profile (e.g. sedation, weight gain, erectile dysfunction, and cognitive blunting).	Comparable safety profile to methadone, though less well- described. Morphine pharmacokinetics is altered in patients with severe renal impairment.
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants.	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants.	Higher. Particularly during treatment initiation.	Comparable safety profile to methadone, though less well-described.
Drug-drug interactions	Few	Few	Higher potential for adverse drug-drug interactions (e.g. antibiotics, antidepressants, antiretrovirals)	Fewer than methadone
Risk of precipitated withdrawal	Yes	No	No	No
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Additional safety considerations	N/A	N/A	Easily mistaken for juice therefore can be dangerous if client lives with other people, especially children, who might ingest accidentally.	Injection use is associated with systemic viral infections such as hepatitis C and HIV, soft tissue infections, bone and joint infections, infective endocarditis, vascular injury, and thrombosis.

	Buprenorphine-based Formulas		Methadone	SROM
	Buprenorphine/ naloxone	Long-Acting Injectable Bup (LAIB)		
Dosing				
Dosing	Health Canada - approved maximum dose of 24 mg, but higher doses (up to 32mg) may be necessary for some people. Alternate day dosing possible. May be suboptimal for some individuals with very high opioid tolerance.	First two months: Monthly dose of 300 mg Maintenance dose: monthly dose of 100 mg (though some patients may benefit from remaining at a 300mg maintenance dose).	No maximum dose specified in the product monograph	No maximum dose specified in the product monograph
Dispensing Frequency	Suitable for immediate dispensed doses, including take-home initiation when indicated, which may contribute to increased people autonomy and cost savings. Advantageous for rural and remote locations.	N/A	Providers have flexibility when determining methadone dispensing intervals. See Table 2.4 for recommendations. First dose of each dispense is witnessed.	DWI recommended. After minimum three (3) months on SROM, gradual schedule for introducing dispensed doses **might** be suitable for some patients who demonstrate exceptional clinical and psychosocial stability. Begin with one initial dispensed dose, and lengthen dispensing by gradually adding dispensed doses that are non-consecutive, up to a maximum of 6 per week.

	Buprenorphine-based Formulas		Methadone	SROM
	Buprenorphine/ naloxone	Long-Acting Injectable Bup (LAIB)		
Switching OAT medications (Rotations)				
Rotation	Easier to rotate from bup/nlx to methadone or SROM.	Comparable to bup/nlx.	Risk of precipitated withdrawal when rotating to bup/nlx. May be rotated directly to SROM.	Risk of precipitated withdrawal when rotating to bup/nlx. May be rotated directly to methadone.
Tapering				
Tapering	Milder withdrawal symptoms; easier to discontinue. May be a better option for individuals with lower-intensity physical opioid dependance.	Milder withdrawal symptoms. Buprenorphine concentrations are decreased slowly over time following the last injection and may take months for buprenorphine to leave the system completely.	More severe withdrawal symptoms.	Comparable to methadone.
UDS				
Initial UDS	Not required to diagnose OUD but helps to confirm opioid use. Discussion of results can be useful to build rapport with patient and help reduce risk to the patient, especially given the increased risk during the first couple of weeks of initiating some OAT.			
Initiation / Stabilization	**Suggest weekly UDS for at least the first month,** at the discretion of provider and for purposes of monitoring.			
Ongoing	Frequency of scheduled appointments is a team decision, individualized for each patient depending on context (e.g., employment), risks (e.g. vulnerability), patient goals (e.g., acquire greater dispensing frequency). Consider signs of stability and patient capacity to comply with UDS requests. When possible, it is recommended that UDS be completed at time of scheduled appointments as a tool for open communication. **If patient is unable to provide a sample, they should still be seen for their appointment**.			

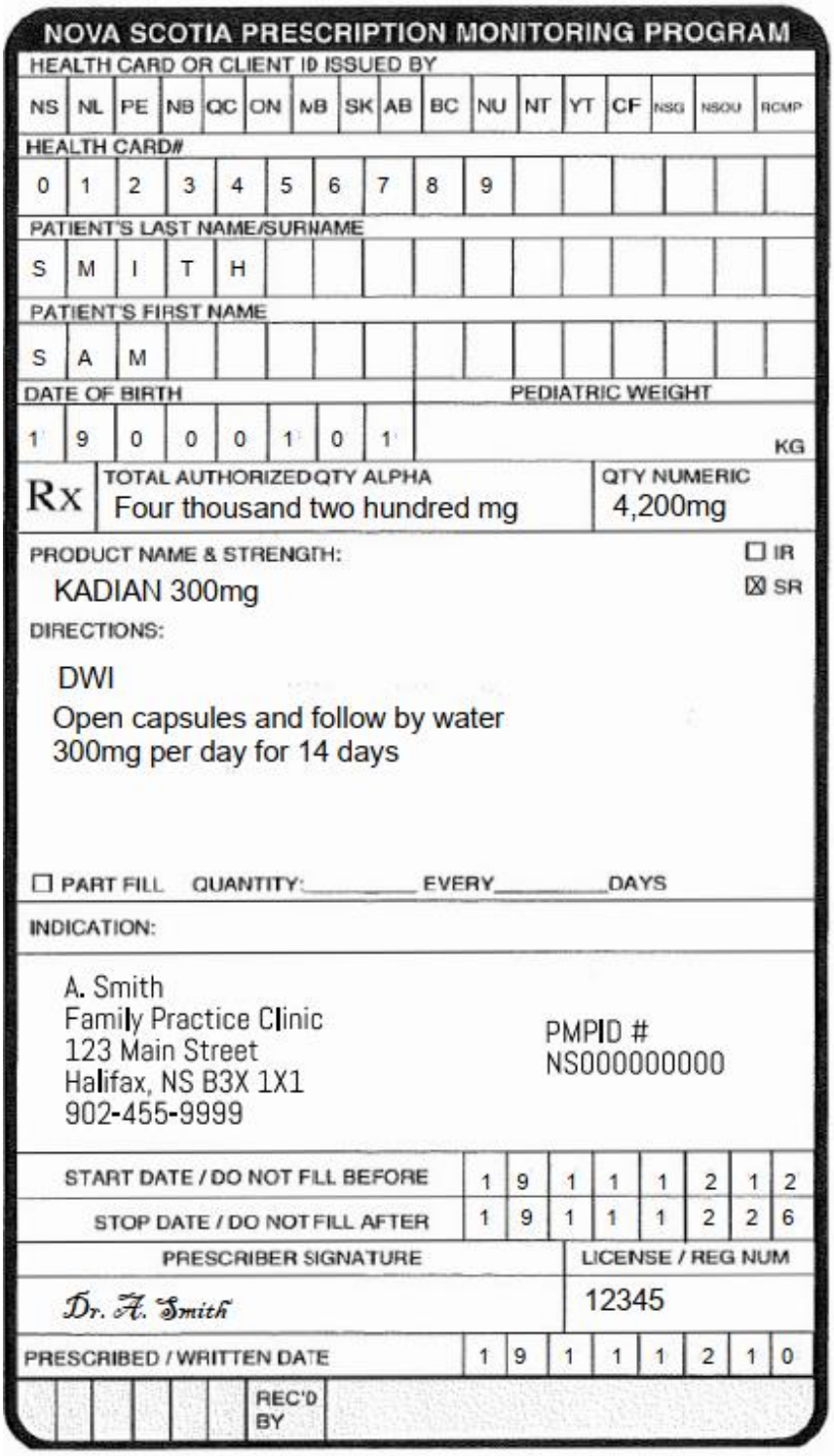
<table>
<tr><td rowspan="2"></td><td colspan="2">Buprenorphine-based Formulas</td><td rowspan="2">Methadone</td><td rowspan="2">SROM</td></tr>
<tr><td>Buprenorphine/ naloxone</td><td>Long-Acting Injectable Bup (LAIB)</td></tr>
<tr><td>Dispensed Treatment</td><td colspan="2">It is also recommended to request four (4) random UDS per year.

Patients can progress from weekly dispensing (standard for bup/nlx) to every other week dispensing after completing two months of random UDS (one per month) with no non-prescribed substance use.</td><td>Random UDS are <u>required</u> for dispensed methadone.

Recommended to request an additional six (6) random UDS per year.</td><td>Random UDS are <u>required</u> for dispensed SROM.

Recommended to request an additional six (6) random UDS per year.</td></tr>
<tr><td colspan="5">More frequent UDS should be clinically indicated, and results should not be used in a punitive way. Alternative UDS frequency (i.e., greater frequency) can be determined by team based on individual patient assessment.</td></tr>
</table>

Appendix B – Sample Prescription Script



NOVA SCOTIA PRESCRIPTION MONITORING PROGRAM

HEALTH CARD OR CLIENT ID ISSUED BY

NS	NL	PE	NB	QC	ON	MB	SK	AB	BC	NU	NT	YT	CF	NSG	NSOU	RCMP

HEALTH CARD#

0	1	2	3	4	5	6	7	8	9

PATIENT'S LAST NAME/SURNAME

S M I T H

PATIENT'S FIRST NAME

S A M

DATE OF BIRTH: 1 9 0 0 0 1 0 1

PEDIATRIC WEIGHT: KG

Rx

TOTAL AUTHORIZED QTY ALPHA: Four thousand two hundred mg

QTY NUMERIC: 4,200mg

PRODUCT NAME & STRENGTH: ☐ IR ☒ SR

KADIAN 300mg

DIRECTIONS:

DWI
Open capsules and follow by water
300mg per day for 14 days

☐ PART FILL QUANTITY:_____ EVERY_____DAYS

INDICATION:

A. Smith
Family Practice Clinic
123 Main Street
Halifax, NS B3X 1X1
902-455-9999

PMPID #
NS000000000

START DATE / DO NOT FILL BEFORE	1	9	1	1	1	2	1	2
STOP DATE / DO NOT FILL AFTER	1	9	1	1	1	2	2	6

PRESCRIBER SIGNATURE: *Dr. A. Smith*

LICENSE / REG NUM: 12345

PRESCRIBED / WRITTEN DATE	1	9	1	1	1	2	1	0

REC'D BY

Appendix C – Sample Home Initiation Schedules

Home Start Buprenorphine Rx

PATIENT DEMOGRAPHIC INFORMATION	
Name	
Health Care #	
DOB	
Phone Number	
Address	
Family Provider	

Buprenorphine/Naloxone 2/0.5 mg tabs

☐ **Usual Dosing**

Day 1: Take **4mg** (2 tablets) SL for withdrawal symptoms as directed, then an additional **2–4 mg** (1–2 tablets) every 2 hours until symptoms are resolved (maximum of **12 mg** (6 tablets) in a day).

Day 2: Take the same total dose you took the first day all at once in the morning. Take an additional **2-4 mg** (1–2 tablets) for withdrawal symptoms (maximum of **16 mg** (8 tablets) in a day).

Day 3: Take the same total dose you took Day 2 in the morning (maximum **16 mg** (8 tablets) in a day)

If on any day you feel sleepy, do not take additional tablets and reduce your dose by **2-4 mg** (1–2 tablets) the next day.

☐ **Low Dose:** Elderly patients or patients taking benzodiazepines

Day 1: Take **2mg** (1 tablet) SL for withdrawal symptoms as directed, then an additional **2mg** (1 tablet) every 2 hours until symptoms are resolved (maximum of **8 mg** (4 tablets) in a day).

Day 2: Take the same total dose you took the first day all at once in the morning. Take an additional **2-4mg** (1–2 tablets) for withdrawal symptoms (maximum of **12 mg** (6 tablets) in a day).

Day 3: Take the same total dose you took Day 2 in the morning (maximum **12 mg** (6 tablets) in a day)

Clonidine

☐ 0.1 mg PO TID PRN for withdrawal symptoms not treated adequately by buprenorphine

NOTE:

- **The above outlines the first 3 days of a home start for Buprenorphine/Naloxone. Consider when the patient will be returning for their next appointment and plan accordingly.**
- **Please include total quantity of tablets/film/mg to dispense**
- **Recommend dispensing 2mg tablets or film for ease of dose adjustment.**
- **Please be aware that pharmacists can independently change dose forms to assist in cost effectiveness for the client.**
- **No observed dose necessary**

Adapted from METAPHI: 27 August 2025

Appendix D – Self-assessment of Opioid Withdrawal Symptoms (SOWS)

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

Patient Instructions:

Before taking first dose of buprenorphine, be sure you are in opioid withdrawal. Usually, it takes several hours (12 hours or longer) after last use of an opioid to go into withdrawal. This can take even longer if methadone was taken.

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: _____

- If score is 17+, it should be safe to take your first dose of buprenorphine.
- If score is 16 or less, wait an hour and then take the test again.

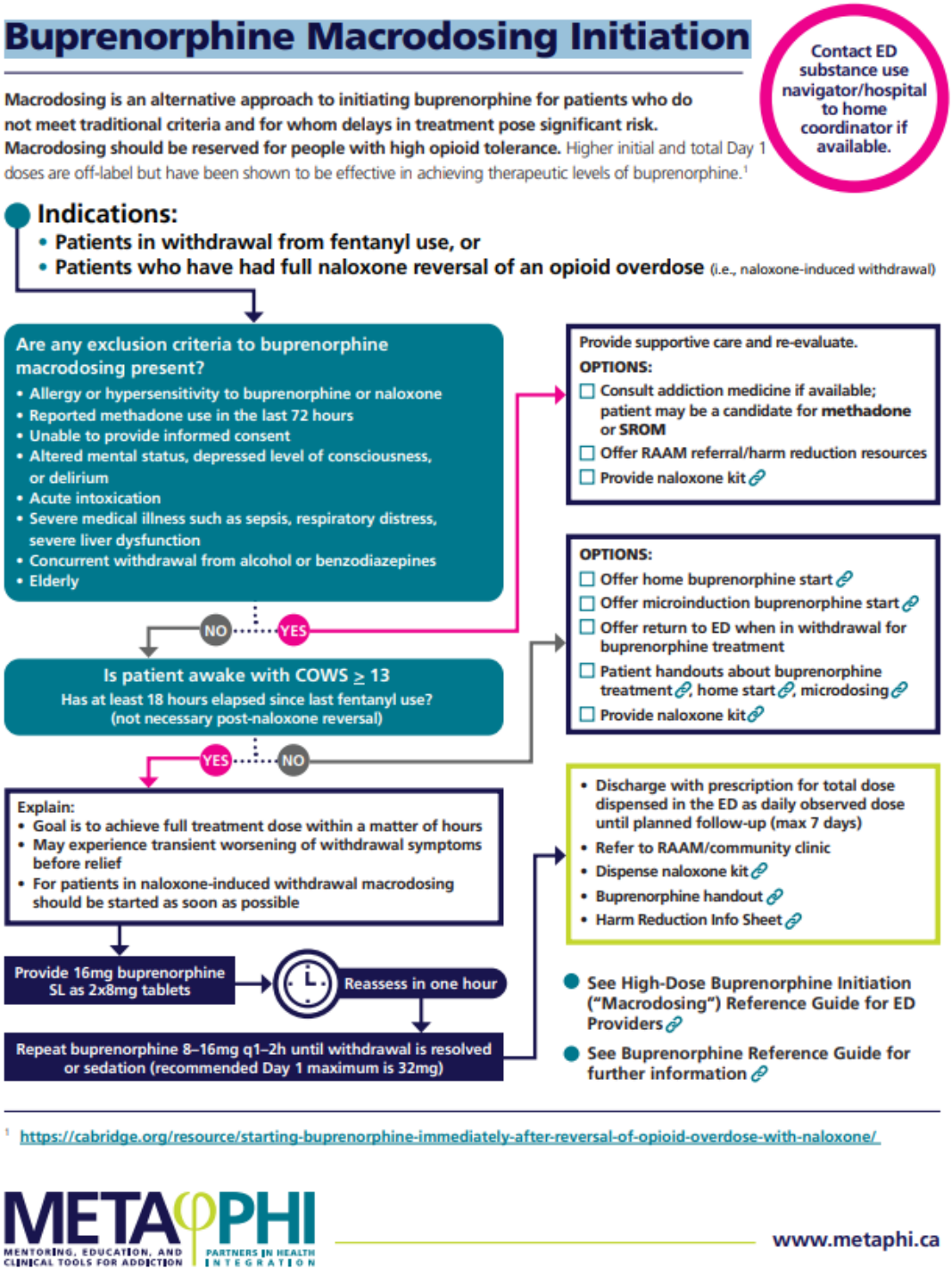
Appendix E – Sample Bup/nlx Micro-dosing Schedules

BC Centre for Substance Use (BCCSU) – 7-day Low-Dose Initiation Protocol		
DAY	BUP/NLX DOSE	OTHER OPIOIDS
1	0.5mg / 0.125mg two times	Continue use
2	0.5mg / 0.125mg three times	Continue use
3	1mg / 0.25mg two times	Continue use
4	2mg / 0.5mg two times	Continue use
5	2mg / 0.5mg three times	Continue use
6	4mg / 1mg three times	Continue use
7	12mg / 3mg once	Stop other opioid use

BC Centre for Substance Use (BCCSU) – 8-day Low-Dose Initiation Protocol		
DAY	BUP/NLX DOSE	OTHER OPIOIDS
1	0.5mg / 0.125mg two times	Continue use
2	1mg / 0.25mg two times	Continue use
3	2mg / 0.5mg two times	Continue use
4	3mg / 0.75mg two times	Continue use
5	4mg / 1mg two times	Continue use
6	6mg / 1.5mg two times	Continue use
7	8mg / 2mg two times	Continue use
8	16mg / 4mg once	Stop other opioid use

Appendix F –Resource for Macro-dosing Initiation (META:PHI, ND)

Note: RAAM is not applicable in Nova Scotia.



Appendix G – NSH Order Set: Bup/Nlx Microdose Initiation

nova scotia health
Yarmouth Regional Hospital

YR00125604 DOB: Jan/1/1971 AGE: 044Y M
TESTERR,TEST
123 STREET P.O.BOX 123
NEW GLASGOW, NS B2H 5C7
Pt. Home Phone: (902)999-9999 UPHI:
FIN CLASS: DOH INS.# EXPIRY:
FD: TEST,DOCTOR 3,BNCWJDBVCJK MDNN
AD: TEST, NON-DOCTOR
REG: Jan/6/2015 AJ0000175/14

ORDER SET

Mental Health and Addictions

Buprenorphine/Naloxone Microdose Initiation

Patient: _____ Allergies: _____

Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (❑) are only to be carried out if checked.

Microdosing is an option for initiation of buprenorphine/naloxone not requiring the patient to experience full opioid withdrawal. This method of initiation must be flexible and responsive to the patient's symptoms. Prescribers are encouraged to contact the Addiction Medicine Consult Service for guidance at 1-855-970-0234.

1. **Investigations**
   - ❑ CBC (profile, no diff)
   - ❑ AST, ALT, GGT
   - ❑ Sodium, potassium, calcium, magnesium, phosphate
   - ❑ Creatinine
   - ❑ ECG
   - ❑ Urine drug screen

2. **Monitoring**
   - Monitor for signs and symptoms of opioid withdrawal or signs of excess sedation. Notify prescriber if these occur.

3. **Medications**

❑ **Methadone dose 40 mg/day or LESS**

Day	Buprenorphine/Naloxone Dose	Methadone Dose Guidance	Methadone Dose
1	0.5 mg/0.125 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
2	1 mg/0.25 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
3	2 mg/0.5 mg SL bid	Full dose (e.g., 40 mg)	Methadone _____ mg po daily
4	3 mg/0.75 mg SL bid	Taper by 5 to 10 mg (e.g., 30 mg)	Methadone _____ mg po daily
5	4 mg/1 mg SL bid	Taper by 5 to 10 mg (e.g., 20 mg)	Methadone _____ mg po daily
6	5 mg/1.25 mg SL bid	Taper by 5 to 10 mg (e.g., 10 mg)	Methadone _____ mg po daily
7	12 mg/3 mg SL daily	Stop methadone	Methadone 0 mg

❑ **Methadone dose 40 mg/day or MORE**

Day	Buprenorphine/Naloxone Dose	Methadone Dose Guidance	Methadone Dose
1	0.5 mg/0.125 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
2	1 mg/0.25 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
3	2 mg/0.5 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
4	3 mg/0.75 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
5	4 mg/1 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
6	5 mg/1.25 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
7	6 mg/1.5 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
8	7 mg/1.75 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
9	8 mg/2 mg SL daily	Full dose (e.g., 120 mg)	Methadone _____ mg po daily
10	9 mg/2.25 mg SL daily	Taper by 10 mg (e.g., 110 mg)	Methadone _____ mg po daily
11	10 mg/2.5 mg SL daily	Taper by 10 mg (e.g., 100 mg)	Methadone _____ mg po daily
12	11 mg/2.75 mg SL daily	Taper by 10 mg (e.g., 90 mg)	Methadone _____ mg po daily
13	12 mg/3 mg SL daily	Taper by 10 mg (e.g., 80 mg)	Methadone _____ mg po daily
14	12 mg/3 mg SL daily	Stop methadone	Methadone 0 mg

Authorized Prescriber's Signature: _____ Reg. No.: _____

Prescriber's Name: _____ Date: _____ Time: _____
Print YYYY/MON/DD HH:MM

AJ0000175/14

Appendix H – OAT Dispensing Frequency Agreement

OAT Dispensing Frequency Agreement

The purpose of this agreement is to ensure the safety requirements around OAT are reviewed and explained by ORP staff and provide space for you to ask questions. Given the risk to you and others, it is important we agree on how to keep everyone safe when taking OAT medication. The points outlined below, as well as your living situation, ability to be regularly assessed, conditions that may impair judgment or safety, medication and substance use interaction and risk, all impact how often you pick up your medications from the pharmacy ("dispensing frequency").

- ☐ As discussed, you are being prescribed:
  - ○ Buprenorphine/naloxone
  - ○ Methadone
  - ○ Slow-release oral morphine (SROM)
  - ○ Other _____
- ☐ The ingestion of even a small amount of your medication by someone for whom it is not prescribed, especially a child, **could result in overdose, poisoning, or death**. For this reason, OAT medication **must be stored in a secure location** that cannot be accessed by other people or pets.
- ☐ Participation in **urine drug testing** is expected and you will be asked to provide urine samples.
- ☐ You will be asked at times to **present to the clinic or your pharmacy with your medication** to ensure that you are taking them as prescribed and storing them securely in an approved container/packaging.
- ☐ ORP staff have explained:
  - ○ The process and reasons for urine drug testing and medication checks.
  - ○ If unexpected results occur, a discussion with you and your provider will determine if/how to adjust your treatment plan, prioritizing your goals and safety, and the safety of others.
  - ○ What to do if you have concerns about providing samples or medication **within 48 hours** of request,
  - ○ The impacts that not being able to complete a UDS / medication check may have on your treatment.

My signature below indicates that I understand and agree to the responsibilities outlined in this agreement, that I have had an opportunity to discuss and review this agreement with someone from the ORP team, and any questions I had have been answered to my satisfaction. **If my situation changes and I can no longer meet these requirements, I understand my dispensing frequency may change.**

Client Signature: _____ ORP Staff Name (print): _____

Date: _____ Date:_____

Appendix I: Excerpts from BCCSU's Safer Tablet Injection (BCCSU et al., 2021)

Injection of oral formulations, whether obtained illicitly or prescribed as a harm reduction measure, is a common method of consuming drugs. To inject oral formulations, tablets are crushed and dissolved in water to produce an injectable solution.

In addition to the **risks associated with frequent non-medical injection (such as sepsis, osteomyelitis, endocarditis, cellulitis, and abscesses)**, there are specific concerns associated with injection of oral formulations, whether prescribed or obtained illicitly. Oral formulations contain excipients including binders, lubricants, coatings, colourings, and emulsifiers that can cause medical complications when injected. **Potential harms associated with injecting oral formulations include local and systemic infections, skin and soft tissue injuries, as well as pulmonary, cardiac, and vascular conditions. (p.1)**

Clinicians should discuss with their patients how harm reduction strategies specific to injecting oral formulations, such as cooking techniques and filtering, can be used in conjunction with other harm reduction practices (e.g., sterile needle and syringe, sterile water, alcohol swabs) to reduce the risks associated with injecting oral formulations.

Provide information on commonly used techniques to prepare oral formulations (p.4).

Two commonly used techniques, hot and cold cooking, have different safety profiles and risks for the patient:

Techniques	Benefits	Risks
Hot Cooking	Kills some bacteria and viruses	Causes some excipients in oral formulations to melt (e.g., wax), which can be more difficult to inject and can cause harm if injected
Cold Cooking	Does not melt excipients in oral formulations, reducing the risk of injecting	Does not kill bacteria or viruses that may be present

While neither hot nor cold cooking consistently produces higher recovery of the active ingredient in oral formulations, the BC Centre for Disease Control (BCCDC) recommends cold cooking.

No cooking technique consistently produces higher recovery of active ingredients. Hot preparation does not consistently produce higher recovery of active ingredient, as may be expected. (p.8)

Of note, Kadian™ tends to coagulate at hot temperatures and produces a lower recovery percentage compared to preparation at cold temperatures. This is possibly due to gelatin present in the Kadian™ formulation forming a non-soluble complex during hot preparation.

Appendix J: UDS – Expected Findings on Spectrometry

(Cheema et al., 2023)

Substance	Expected Findings on Mass Spectrometry
Morphine	Morphine (very high(Hydromorphone (variable, proportionate to dose of morphine) Codeine (trace, i.e., <50 mg/mL)
Heroin	Heroin metabolite 6-acetylmorphine (6-MAM) Morphine (variably high) Codeine (5-10%) 6-acetyl codeine may be present as a contaminant (marker of street heroin)
Hydromorphone	Hydromorphone Hydromorphone 3-glucuronide (hydromorphone metabolite)
Codeine	Codeine (high) Morphine (low)

Appendix K: Tapering Readiness Questionnaire

If you think you might be ready to taper and/or stop opioid treatment, consider these questions to help inform your decision-making.

1. Have you stopped using opioids and/or other substances?	Yes ☐ No ☐
2. Are you able to cope with difficult situations without using substances?	Yes ☐ No ☐
3. Do you have a stable source of income?	Yes ☐ No ☐
4. Do you associate with others who use or sell substances regularly?	Yes ☐ No ☐
5. Are you in employed or in school?	Yes ☐ No ☐
6. Do you have stable housing?	Yes ☐ No ☐
7. Do you live with someone who regularly uses substances?	Yes ☐ No ☐
8. Do you live in close proximity or an area with high substance use?	Yes ☐ No ☐
9. Do you have a support network (ie. partner, family, friends, Elder, clinician)?	Yes ☐ No ☐
10. Do you spend time with people who don't use substances?	Yes ☐ No ☐
11. Would you ask for help if struggling during your taper?	Yes ☐ No ☐
12. Have you been on OAT for a long time?	Yes ☐ No ☐
13. Are you in good state of mental and physical health?	Yes ☐ No ☐
14. Have you tried to stop OAT in the past? What did you learn from this experience?	Yes ☐ No ☐
15. Are you willing to attend more frequent follow up appointments during taper?	Yes ☐ No ☐
16. Do you want to stop taking OAT?	Yes ☐ No ☐

The more "yes" answers you can honestly provide, the greater likelihood you might be ready to make an OAT tapering plan.

Appendix L: Considerations for Enhancing Communication and Collaboration Between ORP Clinic/Providers and Pharmacy Staff

Initial Communication

ORP clinic staff will attempt to reach out to pharmacy staff to determine their capacity to accept the patient and coordinate the patient's care prior to a patient attending a pharmacy. Pharmacy staff are encouraged to call the patient's ORP clinic if the clinic has not yet connected (clinic contact information can be found in Appendix A). When applicable, ORP staff will inform patients that their prescriptions will be entered into the Drug Information System (DIS) to be retrieved by the pharmacist and thus may not be immediately ready at the pharmacy.

ORP clinic staff and Opioid Agonist Therapy (OAT) providers are encouraged to establish and maintain collaborative relationships with community pharmacists. ORP will aim to inform pharmacists of key changes to ORP guidelines, and offer as much clarity and rationale as possible around dosing and dispensing expectations, for example:

- Witnessed dosing requirements
- Return of empty dispensed bottles
- Compliance packaging
- Locked box expectations
- Rationale when writing unexpected medication orders e.g., higher doses of medication or when there is a known drug interaction
- Planning for urgent questions outside of clinic hours, where applicable.

Reciprocal information sharing is especially important:

- For patients newly on OAT or new to a pharmacy
- Regarding a patient's presentation, health or psychosocial circumstances, for example:
    - Pregnancy
    - Relevant changes in medical conditions e.g., signs and symptoms of infection, dental concerns, exacerbation of respiratory issues
    - Medication interactions e.g., planned ECG for methadone or awareness of QTc; addition or change in potentially interacting medication
    - Financial concerns and medication coverage
    - Housing concerns and safe medication storage
    - Administration date and next due date of Long-Acting Injectable Buprenorphine (LAIB).

Ongoing Communication

Pharmacists are part of the patient's care team and are encouraged to:

- Reach out to the provider or ORP clinic with any concerns, including but not limited to:
    - Unexpected prescription orders (e.g., uncommon dose increases, decreases, or dosing intervals).
    - Over-sedation or other clinical concerns identified during patient assessment.

If pharmacist has concerns as above, consider contacting the provider or clinic **before the dose is given** to discuss options. Doses may need to be adjusted, delayed, etc. Dosing without review may pose risk to the patient. Also, if re-assessment is required, contacting the patient after they have left the pharmacy may be difficult, e.g., patient does not have known address or active phone.

- Ensure provider/clinic is made aware of:
    - **All missed doses**, as well as any vomited or partially consumed doses.
    - Pharmacist's prescription renewals/extensions (previously "bridging").
    - Pharmacist's prescription adaptation i.e., dose reductions.
    - Dosing errors.
    - Signs of intoxication or withdrawal.
    - Signs of diversion (including taking medication not as prescribed).
    - Adverse effects.
    - Patient reports dispensed doses are missing.
- Collaborate with the patient's provider and/or another pharmacy to ensure no interruption to OAT dispensing when the pharmacy is closed (e.g., holidays or emergency closures).
- ORP staff are available to troubleshoot with pharmacy staff, if needed, regarding concerns about patient behaviour in the pharmacy, or monies owed, if conversations with the patient have been unsuccessful.
- ORP and pharmacy staff will facilitate patient access to harm reduction information and supplies (e.g., take-home naloxone kits, sterile supplies).
- If a patient is unable to obtain a locked box for dispensed doses, and this presents a barrier to care, pharmacy staff may refer the patient back to their respective clinic to obtain one.

ORP and community pharmacies may be the patient's only connection to the health care system. Given the frequency that patients present to the pharmacy, and occasional difficulties contacting patients (e.g. due to access to phones/messages), the ORP clinical staff may ask for pharmacy support in connecting with patients. Similarly, pharmacy staff are encouraged to contact ORP clinics if they face similar challenges.

All dispensing decisions are ultimately at the discretion of the dispensing pharmacist. Open and respectful communication promotes ongoing collaboration and teamwork. Pharmacists are encouraged to provide ORP staff with any suggestions on how communication can improve. ORP and pharmacy staff are encouraged to contact their respective team lead and/or manager if additional clarification is required, or concerns arise. Managers are encouraged to connect with one another for follow up (ORP contact information Appendix A).

Additional information, if required:

- Guidelines for *Prescribing Opioid Agonist Therapy in MHAP ORP* can be found on the MHAP website, under the Partners and Providers resources tab: https://mha.nshealth.ca/en/clients-and-providers/resources-providers/educational-materials
- Nova Scotia Pharmacy Regulator (NSPR) Standards of Practice: Drug Therapy for the Treatment of Opioid Use Disorder https://nspharmacy.ca/wp-

content/uploads/SOP_Drug-Therapy-for-the-Treatment-of-Opioid-Use-Disorder_Sept2024.pdf

- The **Addiction Medicine Consult Service (AMCS)** is available Monday to Friday 8:30 am to 4:30 pm, offering rapid telephone advice to physicians, pharmacists and nurse practitioners: 1-855-970-0234
- NSPR General Inquiries: info@nspharmacy.ca

NS Health Feedback: 1-844-884-4177, http://www.nshealth.ca/contact-us/patient-feedback

Appendix M: MHAP Correctional Health Services Contact Information

Facility	Role	Phone Number
Provincial	Pharmacist	902-460-7390
Central Nova Scotia Correctional Facility	Mental Health Office	902-460-7407
	Charge Nurse/Nursing Unit/OAT Nurse	902-460-7390
Northeast Nova Scotia Correctional Facility	Social Worker	902-755-7911
	Nursing Unit	902-755-8581
Cape Breton Correctional Facility	Mental Health Nurse	902-563-2116 Ext: 261
	Charge Nurse/Nursing Unit	902-563-2116 Ext: 232
Southwest Nova Scotia Correctional Facility	Social Worker (Team Lead)	902-740-0559
	Nursing Unit	902-742-1831