College of Pharmacists of British Columbia

Board Resolution Minutes
Sent via email March 16, 2020

The following resolution of the Board of the College of Pharmacists of British Columbia is valid and binding as per section 13(12) of the *Health Professions Act*-Bylaws, and has been signed by the following Board members:

Christine Antler, Chair & District 2 Board Member
Anca Cvaci, Vice-Chair & District 6 Board Member
Alex Dar Santos, District 1 Board Member
Andrea Silver, District 3 Board Member
Steven Hopp, District 4 Board Member
Michael Ortynsky, District 5 Board Member
Claire Ishoy, District 7 Board Member
Bal Dhillon, District 8 Board Member
Tracey Hagkull, Government Appointee
Anne Peterson, Government Appointee
Katie Skelton, Government Appointee
Justin Thind, Government Appointee

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1. Be it resolved that the Board amend the effective date of the previously approved amendments to Professional Practice Policy 71 ("PPP-71") – Delivery of Opioid Agonist Treatment, as circulated, to be effective immediately upon approval of the Board.

2. Be it resolved that the Board amend the effective date of the previously approved consequential amendments to the following Professional Practice Policy ("PPP") and associated Policy Guides as circulated, to be effective immediately upon approval of the Board:
    a. PPP-66 Opioid Agonist Treatment
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

Appendix	
1	Signed Board Resolution
2	Board Resolution Briefing Notes

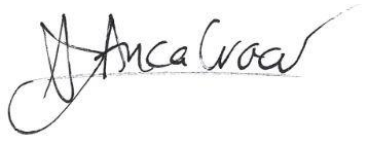
Resolution of the Board of the College of Pharmacists of British Columbia made in accordance with section 13(12) of the *Health Professions Act* – Bylaws.

1. Be it resolved that the Board amend the effective date of the previously approved amendments to *Professional Practice Policy 71* ("PPP-71") – *Delivery of Opioid Agonist Treatment*, as circulated, to be effective immediately upon approval of the Board.

2. Be it resolved that the Board amend the effective date of the previously approved consequential amendments to the following Professional Practice Policy ("PPP") and associated Policy Guides as circulated, to be effective immediately upon approval of the Board:
    a. *PPP-66 Opioid Agonist Treatment*
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

March 17, 2020

Christine Antler, Chair, District 2 — Date



March 17, 2020

Anca Cvaci, Vice-Chair, District 6 — Date

March 16, 2020

Alex Dar Santos, District 1 — Date

March 16, 2020

Andrea Silver, District 3 — Date

March 16, 2020

Steven Hopp, District 4 — Date

	March 16, 2020
Michael Ortynsky, District 5	Date
	March 16, 2020
Claire Ishoy, District 7	Date
	March 17, 2020
Bal Dhillon, District 8	Date
	March 17, 2020
Tracey Hagkull, Government Appointee	Date
	March 17, 2020
Anne Peterson, Government Appointee	Date
	March 17, 2020
Katie Skelton, Government Appointee	Date
	March 16, 2020
Justin Thind, Government Appointee	Date

College of Pharmacists of British Columbia

BOARD DECISION
March 17, 2020

Amendments to the Effective Date of Professional Practice Policy 71 – Delivery of Opioid Agonist Treatment and Consequential Amendments to Professional Practice Policy 66 – Opioid Agonist Treatment and associated Policy Guides

DECISION REQUIRED

Recommended Board Resolutions:

1. Be it resolved that the Board amend the effective date of the previously approved amendments to *Professional Practice Policy 71* ("PPP-71") – *Delivery of Opioid Agonist Treatment*, as circulated, to be effective immediately upon approval of the Board.

2. Be it resolved that the Board amend the effective date of the previously approved consequential amendments to the following Professional Practice Policy ("PPP") and associated Policy Guides as circulated, to be effective immediately upon approval of the Board:

    a. *PPP-66 Opioid Agonist Treatment*
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

Purpose

To request that the Board of the College of Pharmacists of British Columbia ("the Board") amend the effective date of the previously approved amendments to *PPP-71 Delivery of Opioid Agonist Treatment* and consequential amendments to the following PPP and associated Policy Guides, to be effective immediately upon approval of the Board:

    a. *PPP-66 Opioid Agonist Treatment*
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

Background

At the February 14, 2020, meeting of the Board, the Board approved amendments to *Professional Practice Policy (PPP) 71 – Delivery of Opioid Agonist* and consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides effective April 1, 2020 (see Appendix 1). The decision to allow these amendments to come into force on this date was to enable the implementation plan, and ensure necessary communication of changes to stakeholders.

On March 11, 2020, the World Health Organization declared the novel coronavirus, COVID-19, a pandemic, citing concern over alarming levels of spread and severity across the globe. The novel coronavirus has caused a global outbreak of respiratory infections since its discovery in December 2019.

The situation regarding COVID-19 continues to evolve here in BC, Canada and other jurisdictions in the world. The College of Pharmacists of BC is working closely with the Ministry of Health and other partners to support the response to this new illness as part of BC's health system.

Discussion

Recent consultations with the BC Centre on Substance Use, BC College of Nursing Professionals, College of Physicians and Surgeons of BC, First Nations Health Authority, Ministry of Health, and Office of the Provincial Health Officer have indicated that in light of the risk of a widespread COVID-19 outbreak in British Columbia, the effective date of *PPP-71 Delivery of Opioid Agonist Treatment* should be amended to be effective as soon as possible. This will support delivery of opioid agonist treatment to patients.

Communication of the changes to stakeholders will be expedited to facilitate implementation of the amendments to *PPP-71 Delivery of Opioid Agonist Treatment*, *PPP-66 Opioid Agonist Treatment* and associated Policy Guides. Additionally, guidance on how to use the existing Controlled Prescription Program forms with the new PPP-71 amendments will be provided.

Next Steps

The Board has the authority to amend PPPs. As such, if approved by the Board, the effective date of the previously approved amendments to *PPP-71 Delivery of Opioid Agonist Treatment* and the consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides would come into effect immediately.

Recommendation

The Legislation Review Committee recommends that the Board amend the effective date of the previously approved amendments to *PPP-71 Delivery of Opioid Agonist Treatment* and the previously approved consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides, to be effective immediately, by signing the attached Resolution (Appendix 2).

Appendix	
1	February 2020 Board Briefing Materials
2	Board Resolution Signature Page

College of Pharmacists of British Columbia

BOARD MEETING
February 14, 2020

7. Legislation Review Committee
b) Amendments to Professional Practice Policy 71 – Delivery of Methadone for Maintenance

DECISION REQUIRED

Recommended Board Motions:

1. Approve amendments to *Professional Practice Policy 71* ("PPP-71") – *Delivery of Methadone for Maintenance*, as circulated, to be effective April 1, 2020.

2. Approve consequential amendments to the following Professional Practice Policy ("PPP") and associated Policy Guides as circulated, to be effective April 1, 2020:

    a. *PPP-66 Opioid Agonist Treatment*
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

Purpose

To propose the following policy changes:

- Amendments to *PPP-71 Delivery of Methadone for Maintenance*
- Consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides

Background

Developed in 2013, *PPP-71 Delivery of Methadone for Maintenance* currently permits pharmacists working in community pharmacies to deliver methadone for maintenance to a patient's home only if the physician authorizes the delivery due to the patient's immobility. At the time it was developed, it was understood that federal legislation did not support the delivery of methadone by pharmacists. However, *PPP-71 Delivery of Methadone for Maintenance* was established to create a way to ensure best patient health outcomes and continuity of care, when patients have restrictions in mobility that would require the delivery of methadone for maintenance.

In September 2018, Health Canada released the Transportation of Controlled Substances in Canada policy position ("policy position"), which states pharmacists are permitted to transport controlled substances to a patient with an appropriate prescription.[1] In addition, the clinical guidelines and requirements for opioid agonist treatment ("OAT") have changed since 2013. The College of Pharmacists of BC ("the College") now has policies setting requirements for dispensing two other OAT drugs (i.e., buprenorphine/naloxone and slow release oral morphine). However, the College has not established provisions regarding pharmacist transportation of those drugs. Further, federal requirements have been amended to authorize nurse practitioners to prescribe OAT. In light of these changes, amendments to *PPP-71 Delivery of Methadone for Maintenance* are proposed.

Discussion

Consultations with internal and external stakeholders were held throughout the process of developing amendments to this policy (see Appendix 1). Additionally, the policies and positions of other pharmacy regulatory authorities on OAT delivery were sought out and reviewed to inform the proposed amendments (see Appendix 2). Taking these into consideration, proposed amendments to the policy were made, and include those listed below.

1. **Policy broadened to include buprenorphine/naloxone and slow release oral morphine in addition to methadone.**
   Since the implementation of *PPP-71 Delivery of Methadone for Maintenance* in 2013, the College released guidelines for providing services related to buprenorphine/naloxone and slow release oral morphine. Previously there were no established provisions for the transportation of these drugs. The policy is proposed to apply broadly to all three oral OAT drugs. To improve alignment with this proposed policy change, the proposed title of the PPP is *"PPP-71 Delivery of Opioid Agonist Treatment"*.

2. **Delivery location is no longer restricted to a patient's home address, but will now be permitted at a location that is safe for both the patient and the pharmacist, is private, maintains confidentiality of the patient, and has a verifiable address.**
   The requirement for delivery to a patient's home address was removed, and new principle-based criteria for delivery locations were implemented to allow for more flexibility in delivery location. Several other pharmacy regulatory authorities do not restrict the delivery of OAT to a patient's home address, and removal of this restriction was broadly supported by external stakeholders as it supports access to treatment.

[1] https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/transportation-of-controlled-substances-in-canada.html

3. **Reason for delivery is no longer restricted to immobility or extraordinary circumstances, and a pharmacist may provide delivery if it is safe, appropriate and in the best interest of the patient to do so.**
   The release of Health Canada's policy position has led to the reassessment of many aspects of *PPP-71 Delivery of Methadone for Maintenance*, which was initially put in place as an exception to federal legislation. Now that delivery of controlled substances is no longer interpreted to be an exception to the rule, the necessity of restrictions placed on delivery were re-examined. Removal of restriction on reason for delivery was widely supported during internal and external stakeholder consultations. A requirement that the pharmacist ensure delivery is safe, appropriate and in the best interest of the patient, and a requirement to document their rationale are proposed in the policy amendments for patient safety.

4. **Delivery no longer requires physician authorization, and a pharmacist may use their professional judgement to decide to deliver OAT to a patient.**
   As described above, the Health Canada policy position states that delivery of controlled substances by a pharmacist directly to a patient with a valid prescription is permitted. Because of the proposed amendment to no longer restrict delivery to patients who are immobile, a physician assessment and authorization for delivery would no longer be required. Community pharmacists are able to assess patients and determine if delivery is safe, appropriate and in their best interest. It is proposed that pharmacists be required to notify the prescriber that they have decided to initiate or stop delivery. Prescribers indicated that this was important information for them to know, to ensure the circle of care is informed of the treatment plan.

   A proposed provision was added stating that if a prescriber indicates that delivery is not permitted, the pharmacist must not initiate delivery to that patient, which aligns with the proposed changes to the Controlled Prescription Program form, as well as requests from prescribers (see Appendix 4).

5. **New safety provisions included in the policy.**
   In addition to the proposed requirement to deliver to a location that is safe for both the patient and the pharmacist, a provision has been proposed that allows a pharmacist to refuse to deliver OAT if there is concern for the safety of the patient, the pharmacist, or the public. Additionally, it is proposed that pharmacy managers must have written policies and procedures in place to ensure the safety and security of the patient, pharmacist and drug during the delivery. These provisions are recommended keeping in mind that the pharmacist providing the delivery will also be performing a patient assessment and witnessed ingestion at a patient's location, outside of the traditional pharmacy setting. Additionally, pharmacists would be transporting controlled substances which may be targets of theft, and adequate security measures should be put in place.

Additional proposed amendments to the policy include a strengthened recommendation for pharmacists to refer a patient to another pharmacy if providing delivery service is not feasible within the services and resources of the pharmacy, and clarification that due to the requirement for patient assessment prior to releasing the OAT drug, only a pharmacist (e.g., not a pharmacy technician or courier) may deliver OAT. *PPP-66 Opioid Agonist Treatment* and associated Policy Guides are referenced in the updated policy, as all the requirements in these still apply when OAT is delivered.

The internal and external stakeholder consultations revealed areas of the policy that required further clarification. Several groups provided feedback, requesting information on how other health care practitioners fit into this policy. At this time, models of delivery that include other health care providers are considered outside of the scope of this policy. It has been clarified in the policy preamble that this policy applies only to pharmacists delivering OAT directly to a patient, as specified by the Health Canada policy position.

During consultations, requiring documentation in PharmaNet that the OAT drug was delivered was discussed. Documenting this information the 'sig field' in PharmaNet was considered as an option, but limitations were identified, including that the 'sig field' is only able to display a limited number of characters. Another possibility discussed was using product identification numbers (PINS) to indicate when an OAT drug is delivered, similar to the existing practice for methadone when prescribed for OAT; however, currently no PINS for delivery of buprenorphine/naloxone or slow release oral morphine exist. Given the limitations with the 'sig field' and because information on whether or not the OAT drug was delivered would be available by calling the pharmacy as the proposed amendments to the policy include documenting the delivery date, time and address for each delivery in the patient record, no additional requirements to document that the OAT drug is delivered in PharmaNet are proposed.

In recognition that having delivery information available in PharmaNet for <u>all</u> forms of OAT may be valuable as patients move through different care settings, discussions on developing delivery PINS for buprenorphine/naloxone and slow release oral morphine with the Ministry of Health will be further pursued.

Lastly, due to the proposed changes to *PPP-71 Delivery of Methadone for Maintenance* and the Controlled Prescription Program duplicate forms, consequential amendments are proposed to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides (see Appendix 5). Additional proposed amendments stemming from recent PPP changes as part of the *Pharmacy Operations and Drug Scheduling Act* Modernization Phase Two project have also been included in these proposed consequential amendments.

Next Steps

The Board has the authority to amend PPPs. As such, if approved by the Board, the proposed amendments to *PPP-71 Delivery of Methadone for Maintenance* and the consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides would come into effect on April 1, 2020. Allowing these amendments to come into force on this date will enable the implementation plan, and ensure necessary communication of changes to stakeholders.

Recommendation

The Legislation Review Committee recommends that the Board approve the proposed amendments to *PPP-71 Delivery of Methadone for Maintenance* and the consequential amendments to *PPP-66 Opioid Agonist Treatment* and associated Policy Guides, to be effective April 1, 2020.

Appendix	
1	List of Stakeholders Consulted
2	Jurisdictional Scan Summary
3	Amendments to *PPP-71 Delivery of Methadone for Maintenance* (track changes and clean)
4	Amendments to the Controlled Prescription Program Forms Briefing Note (Feb 14, 2020)
5	Consequential amendments PPP-66 & Policy Guides (track changes)

Appendix 1: List of Stakeholders Consulted on *PPP-71 Delivery of Methadone for Maintenance* Amendments

The following stakeholders provided feedback on the draft policy amendments:

- College of Physicians and Surgeons of BC (CPSBC)
- British Columbia College of Nursing Professionals (BCCNP)
- College of Pharmacists of BC (CPBC) Pharmacy Advisory Committee
- Patient representatives
- British Columbia Centre for Substance Use (BCCSU)
- Doctors of British Columbia (DOB)
    - Council on Health Promotion
    - Section of Emergency Medicine
    - BC Psychiatric Association
- Nurses and Nurse Practitioners of BC (NNPBC)
- BC Pharmacy Association (BCPhA)
- First Nations Health Authority
- Neighborhood Pharmacy
- Lower Mainland Pharmacy Services

Appendix 2: Jurisdictional Scan Summary

Current Pharmacy Regulatory Authority (PRA) Policies and Positions on OAT Delivery

Methadone/OAT Delivery	**BC** (current policy)	**AB**	**SK**	**MB**	**ON**	**QC**	**NB**	**NL**	**NS**	**PEI**
PRA restricts reason for delivery (i.e. extraordinary or emergency circumstances)	✓	×	✓	✓	✓	×	✓	✓	✓	--
PRA requires prescriber to authorize (AUTH) or agree to (AGR) delivery	✓ AUTH	×	✓ AUTH	✓ AUTH	✓ AGR	×	✓ AGR	×	✓ AGR	×
PRA allows pharmacist to use professional judgement to make determination to deliver	--	✓	--	✓[i]	--	✓	--	✓	✓[ii]	--
PRA only permits pharmacist to deliver OAT	✓	✓[iii]	--	✓	--	✓[iv]	✓[v]	✓	✓	--
PRA only permits patient to receive OAT delivery	✓	✓[vi]	--	✓[vii]	--	✓	✓	✓	✓	--
PRA restricts OAT delivery to patient's home	✓	×	✓	--	✓	×	✓	×	×	×
PRA requires pharmacist to provide clinical assessment prior to releasing delivered dose	✓	✓	--	✓	--	✓[viii]	✓	✓	✓	--
PRA requires pharmacist to be present to witness ingestion	✓	✓[ix]	--	✓	✓	✓[x]	✓	✓	✓	--

✓	Yes, required or expected by PRA, formally (i.e. in policy) or informally (i.e. expectation of PRA but not addressed directly in policy)
✓	Yes, required or expected by PRA, formally or informally with additional caveats (see footnotes)
×	No, not required or expected by PRA
--	Not addressed in PRA requirements, or not relevant based on other requirements

[i] Professional judgement of pharmacist, in addition to the prescriber's authorization, is required to determine that delivery is necessary.
[ii] If a prescriber was unavailable to consult with, pharmacist could use their professional judgement to make the determination of whether the delivery would be appropriate.
[iii] Delivery may be delegated to another authorized health professional.
[iv] Delivery may be delegated to nurse
[v] Pharmacist may be required to transfer custody of individually-labeled doses of methadone.
[vi] Carries and take-home doses of ORT may be delivered to patient's agent
[vii] Delivery may also occur directly to community health facility or hospital as authorized by new Health Canada exemptions
[viii] Assessment may be completed by nurse, if nurse has been delegated to deliver
[ix] Pharmacist or another delegated health professional must witness ingestion
[x] Witnessed ingestion may be completed by nurse, if nurse has been delegated to deliver

Appendix 3

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-71**
POLICY FOCUS: **Delivery of ~~Methadone for Maintenance~~Opioid Agonist Treatment**

This policy provides guidance to pharmacists and pharmacy managers working in community pharmacy settings on the delivery of opioid agonist treatment (OAT) drugs by pharmacists directly to patients.[1] This policy does not apply to injectable opioid agonist treatment.

The *Pharmacy Operations and Drug Scheduling Act* Bylaws sections 18(2)(b-e), (l), (m)~~,~~ and (t), 19(4), 19(6)(a-~~,~~b), 23(1)(a-~~,~~b), 23.1(1), and 36, and the *Health Professions Act* Bylaws Schedule F, Part 1 - *Community Pharmacy Standards of Practice* supplement this policy. This policy must be read in conjunction with *Professional Practice Policy – 66 Opioid Agonist Treatment* and its associated Policy Guides.

POLICY STATEMENT~~(S)~~:

~~Under extraordinary circumstances, if the patient has restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of methadone for maintenance. This practice is the exception to the rule and not normal practice.~~
~~**Neither the pharmacy manager nor the staff pharmacist may authorize the provision of home delivery for methadone in the absence of the prescriber's authorization on the prescription.**~~

~~**Delivery Standards:**~~

~~**1. Prescribing Physician Authorization of Home Delivery**~~

~~a. Should the prescribing physician determine that, due to the patient's immobility, delivery is required; the physician may authorize delivery by signing the declaration on the Methadone Maintenance Program, Controlled Prescription Program form.~~

~~i. If the pharmacist or pharmacy technician has concerns regarding the authenticity of the prescriber's signature they must contact the prescriber for verification.~~

~~ii. Physicians will not authorize delivery unless patient safety is assured and restrictions in mobility have been identified.~~

~~iii. Distance between patient home and pharmacy does not qualify as a restriction in mobility.~~

1. Determination to Deliver OAT

a. A pharmacist may deliver OAT to a patient from whom they have received a valid OAT prescription, if using their professional judgement, the pharmacist determines that providing delivery is safe, appropriate and in the best interest of the patient.
b. The pharmacist must document in the patient's record the decision to deliver or to not deliver, including the rationale for the decision. This documentation must be easily retrievable.
c. The pharmacist must notify the prescriber of the decision to intiate or stop delivery as soon as reasonably possible, and this must be recorded in the patient's record.
d. A pharmacist may refuse to deliver OAT if there is concern for the safety of the patient, pharmacist or public. Where appropriate, the pharmacist should discuss any concerns with the prescriber to resolve issues in the best interest of the patient.
e. A pharmacist must not deliver OAT to a patient if the prescriber indicates that delivery is not permitted.
f. If delivery is not feasible within the services and resources the pharmacy provides, the patient should be referred to a pharmacy that can provide the delivery.

2. ~~Home~~ Delivery ~~Schedule and Location~~of OAT

If ~~delivery is authorized~~ a pharmacist has made the determination to deliver OAT to a patient as noted in section 1 ~~above~~, the pharmacist must meet the following delivery requirements:

[1] Transportation of Controlled Substances in Canada: https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/transportation-of-controlled-substances-in-canada.html

~~a. The pharmacist must determine whether home delivery is feasible within the services and resources the pharmacy provides. If the pharmacy does not provide delivery service – it may be appropriate to refer the patient to a pharmacy that can provide the delivery.~~

a. The pharmacist must work with the patient to make arrangements for delivery that are in the best interest of the patient. Arrangements must include:
   i. A delivery location that is private, maintains the confidentiality of the patient, is safe for both the patient and the pharmacist, and has a verifiable address.
   ii. Time(s) and date(s) for delivery.
   iii. Procedure if the patient is not available at the location to receive the OAT delivery including communication of appropriate alternate arrangements for the patient to obtain their OAT drug.
b. The OAT drug must be packaged in the pharmacy and dispensed with the appropriate labelling.
c. A pharmacist must release an OAT drug to a patient in accordance with *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides.
d. Due to the requirement for a pharmacist to assess a patient prior to releasing an OAT drug,
   i. only a pharmacist may deliver OAT to a patient,
   ii. the OAT drug must only be delivered directly to the patient, and
   iii. the OAT drug must not be left with any other person.
e. In addition to meeting the requirements for documentation set out in *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides, pharmacists must record the delivery date, time and address for each delivery on the patient record, which includes the patient specific accountability log.

~~b. If the pharmacy is able to provide home delivery the pharmacist must work with the patient to make appropriate arrangements for delivery. Arrangements must include:~~
   ~~i. Address for delivery - methadone may only be delivered to a patient's home with a valid street address; delivery to a public location is not permitted.~~
   ~~ii. Time for delivery.~~
   ~~iii. Procedure if patient not available at address to receive methadone delivery including communication of appropriate alternate arrangements for the patient to obtain their prescription.~~

~~Note: *It is not acceptable for the pharmacist to deliver the methadone to an alternate person or location or to leave the methadone unattended*~~.

3. ~~Secure Transportation and Storage~~Safety and Security

a. The pharmacy manager must ensure that written policies and procedures are in place to ensure the safety of the patient and the pharmacist and the security of the drug during the delivery.

~~a.~~b. The dispensing pharmacist is responsible for securely transporting and appropriately storing ~~methadone~~the OAT drug.

~~b. Methadone must be transported directly from the dispensing pharmacy to the patient's home address; methadone~~ OAT drugs may not be stored outside of the pharmacy under any circumstances, nor be left unattended if the delivery is unsuccessful.~~.~~

c. ~~**Release of Methadone for Maintenance**~~

~~The pharmacist must be present to:~~
~~Confirm the identity of the patient.~~
~~Assess the competence of the patient.~~

~~a.~~

~~b. Witness the release and ingestion of methadone to the patient, this responsibility cannot be delegated to a pharmacy technician or any other pharmacy support staff.~~

~~c. Provide appropriate patient counseling.~~

~~d. If carries are provided, the pharmacist must always witness first dose of the take-home prescription; all subsequent doses must be dispensed in child-resistant containers with explicit warning label(s).~~

Appendix 3

4. Documentation

The pharmacist must:

a. At the time of release of a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific part-fill accountability log. Neither party may 'pre-sign' for future doses.
b. Document any and all home deliveries of methadone in the patient's record.
c. Log the home delivery with the address where the delivery was made on the methadone part-fill accountability log.
d. Document any appropriate follow-up plan in the patient's record.
e. File the methadone part-fill accountability log with original methadone prescription form.

BACKGROUND:

Legislation

Federal legislation does not support delivery of narcotics. The Controlled Drugs and Substances Act (CDSA) defines the transport or delivery of narcotics as trafficking, the Narcotic Control Regulations (NCR) limit the transport of narcotics to licensed dealers only.

Controlled Drugs and Substances Act

"Section 2 - Interpretation, Definitions[1]

"traffic" means, in respect of a substance included in any of Schedules I to IV,

(*a*) to sell, administer, give, transfer, ***transport***, send or ***deliver*** the substance"

Narcotic Control Regulations

"Section 2 - Interpretation, Definitions[2]

"licensed dealer" means the holder of a licence issued under section 9.2.

Dealers' Licenses and Licensed Dealers[3]

8. *(1) Subject to these Regulations, no person* ***except a licensed dealer*** *shall produce, make, assemble, import, export, sell, provide,* ***transport, send or deliver a narcotic****."*

Pharmacists are required to adhere to the CDSA and its regulations as well as the *Health Professions Act*, *Pharmacy Operations and Drug Scheduling Act* and their *Bylaws*. The College of Pharmacists and the College of Physicians and Surgeons recognize that there are extraordinary circumstances where due to temporary or permanent restrictions in mobility patients would require delivery of their methadone for maintenance to ensure best patient health outcomes and continuity of care.

1

2

3 http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-3.html#docCont

First approved: 21 Jun 2013 **PPP-71**
Revised:
Reaffirmed:

Appendix 3

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-71**
POLICY FOCUS: **Delivery of Opioid Agonist Treatment**

This policy provides guidance to pharmacists and pharmacy managers working in community pharmacy settings on the delivery of opioid agonist treatment (OAT) drugs by pharmacists directly to patients.[1] This policy does not apply to injectable opioid agonist treatment.

The *Pharmacy Operations and Drug Scheduling Act* Bylaws sections 18(2)(b-e), (l), (m) and (t), 19(4), 19(6)(a-b), 23(1)(a-b), 23.1(1), and 36, and the *Health Professions Act* Bylaws Schedule F, Part 1 - *Community Pharmacy Standards of Practice* supplement this policy. This policy must be read in conjunction with *Professional Practice Policy – 66 Opioid Agonist Treatment* and its associated Policy Guides.

POLICY STATEMENTS:

1. **Determination to Deliver OAT**
    a. A pharmacist may deliver OAT to a patient from whom they have received a valid OAT prescription, if using their professional judgement, the pharmacist determines that providing delivery is safe, appropriate and in the best interest of the patient.
    b. The pharmacist must document in the patient's record the decision to deliver or to not deliver, including the rationale for the decision. This documentation must be easily retrievable.
    c. The pharmacist must notify the prescriber of the decision to intiate or stop delivery as soon as reasonably possible, and this must be recorded in the patient's record.
    d. A pharmacist may refuse to deliver OAT if there is concern for the safety of the patient, pharmacist or public. Where appropriate, the pharmacist should discuss any concerns with the prescriber to resolve issues in the best interest of the patient.
    e. A pharmacist must not deliver OAT to a patient if the prescriber indicates that delivery is not permitted.
    f. If delivery is not feasible within the services and resources the pharmacy provides, the patient should be referred to a pharmacy that can provide the delivery.

2. **Delivery of OAT**
    If a pharmacist has made the determination to deliver OAT to a patient as noted in section 1, the pharmacist must meet the following delivery requirements:
    a. The pharmacist must work with the patient to make arrangements for delivery that are in the best interest of the patient. Arrangements must include:
        i. A delivery location that is private, maintains the confidentiality of the patient, is safe for both the patient and the pharmacist, and has a verifiable address.
        ii. Time(s) and date(s) for delivery.
        iii. Procedure if the patient is not available at the location to receive the OAT delivery including communication of appropriate alternate arrangements for the patient to obtain their OAT drug.
    b. The OAT drug must be packaged in the pharmacy and dispensed with the appropriate labelling.
    c. A pharmacist must release an OAT drug to a patient in accordance with *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides.
    d. Due to the requirement for a pharmacist to assess a patient prior to releasing an OAT drug,
        i. only a pharmacist may deliver OAT to a patient,
        ii. the OAT drug must only be delivered directly to the patient, and
        iii. the OAT drug must not be left with any other person.
    e. In addition to meeting the requirements for documentation set out in *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides, pharmacists must record the delivery date, time and address for each delivery on the patient record, which includes the patient specific accountability log.

[1] Transportation of Controlled Substances in Canada: https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/transportation-of-controlled-substances-in-canada.html

Appendix 3

3. Safety and Security

a. The pharmacy manager must ensure that written policies and procedures are in place to ensure the safety of the patient and the pharmacist and the security of the drug during the delivery.
b. The dispensing pharmacist is responsible for securely transporting and appropriately storing the OAT drug.
c. OAT drugs may not be stored outside of the pharmacy under any circumstances, nor be left unattended if the delivery is unsuccessful.

First approved: 21 Jun 2013 **PPP-71**
Revised:
Reaffirmed:

College of Pharmacists of British Columbia

BOARD MEETING
February 14, 2020

7. Legislation Review Committee
c) Amendments to the Controlled Prescription Program Forms

DECISION REQUIRED

Recommended Board Motion:

Approve amendments to the Controlled Prescription Program forms to create a harmonized form, as circulated.

Purpose

To propose amendments to the Controlled Prescription Program forms to create a harmonized form.

Background

Controlled Prescription Program

The Controlled Prescription Program ("CPP") is a duplicate prescription program created to prevent forgeries and reduce inappropriate prescribing of drugs listed in Schedule 1A[1]. Prescriptions for drugs specified in the CPP must be written on a duplicate form specifically developed for this purpose.

Currently, there are two CPP forms in use. A generic CPP form used for the majority of controlled prescriptions (see Appendix 1), and a methadone CPP form which is used to prescribe methadone for maintenance treatment (see Appendix 2).

Controlled Prescription Program Advisory Committee

The Controlled Prescription Program Advisory Committee ("CPPAC") is a multi-organization committee established in August 2018 with members from the Ministry of Health and the health regulators of professions that prescribe or dispense controlled drugs. The purpose of the

[1] In B.C., drugs are scheduled in the DSR as Schedule I, IA, II, III, and IV. The schedules are differentiated as follows:

- Schedule I (Prescription)
- Schedule IA (Prescription - Triplicate/Duplicate Prescription Program)
- Schedule II (Non-Prescription – Retained within the Professional Service Area)
- Schedule III (Non-Prescription – Available for self-selection in the Professional Products Area)
- Schedule IV (Prescription by Pharmacist)

CPPAC is to regularly review and recommend updates to the list of controlled (Schedule 1A) drugs, and provide a forum to share knowledge and coordinate practices around drugs with a high-risk profile.

Discussion

In 2017, the BC Centre on Substance Use released new Provincial Guidelines for the Clinical Management of Opioid Use Disorder, which is the new provincial clinical practice guideline for all clinicians who wish to prescribe oral opioid agonist treatments ("OAT") (i.e., methadone, buprenorphine/naloxone and slow release oral morphine).

Since the release of the new guidelines, prescribers have been using the generic CPP form to prescribe buprenorphine/naloxone and slow release oral morphine for OAT in absence of a generic OAT CPP form. This creates inconsistencies amongst prescriptions for OAT drugs as prescriptions written on the generic CPP form are "void after 5 days"[2] whereas prescriptions for methadone for OAT are not as they include a "start day" and "last day".

In 2018, the CPPAC discussed the need for amendments to the current CPP forms. Also discussed was the idea of potentially only having a harmonized CPP form with a section for OAT. The CPPAC discussed the benefits of having a harmonized CPP form which include:

- A consistent approach to writing prescriptions for all 1A drugs;
- Increased patient access to OAT therapy, as all physicians will have the form (currently only OAT prescribers have the methadone CPP form); and,
- Reduce the administrative burden associated with ordering/printing of two pads for 1A drugs.

In November 2019, the CPPAC developed a harmonized CPP form for the prescribing of all 1A drugs (see Appendix 3). The proposed amendments to *PPP-71 Delivery of Methadone for Maintenance* were considered in the development of this harmonized CPP form. For instance, the harmonized CPP form no longer requires physician authorization for delivery. As specified in proposed amendments to *PPP-71 Delivery of Methadone for Maintenance*, pharmacists may use their professional judgement to determine whether or not to deliver OAT to the patient. Using the new harmonized CPP form, the prescriber may specify that delivery is not permitted.

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[2] *Controlled Prescription Program*, http://library.bcpharmacists.org/6_Resources/6-4_Drug_Distribution/5015-ControlledPrescriptionProgram.pdf
"Void after 5 days" means that the prescription cannot be honoured after midnight of the fifth day following the date of issue. Therefore, a prescription written on January 10th can be accepted for filling or logging on until midnight January 15th.

Next Steps

In accordance with section 19(6)(a) of the *Pharmacy Operations and Drug Scheduling Act* Bylaws, drugs included in the controlled prescription program must not be sold or dispensed unless the registrant has received the prescription on the CPP form approved by both the College of Pharmacists of BC Board and the College of Physicians and Surgeons of British Columbia (CPSBC).

The CPSBC approved the harmonized CPP form in January 2020 (see Appendix 4). As such, if approved by the Board, the new harmonized CPP form will be sent to the Ministry of Health for printing.

To provide time for prescribers and pharmacists to update their practices, as well as phase out the current CPP forms, the CPPAC and Ministry of Health will advise the College of the effective date of this amendment.

Recommendation

That the Legislation Review Committee recommend that the Board approve the amendments to the CPP form.

Appendix	
1	Generic CPP Form
2	Methadone CPP Form
3	Harmonized CPP Form
4	CPSBC Executive Committee Meeting Minutes

Appendix 5

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-66**
POLICY FOCUS: **Opioid Agonist Treatment**

This policy provides guidance to registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment. This policy must be read in conjunction with *PPP-71 Delivery of Opioid Agonist Treatment.*

POLICY STATEMENTS:

Effective January 1, 2019:

1. All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or
    b. successfully complete the British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and
    c. record self-declaration of training completion in eServices.
2. All pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the CPBC MMT training program (2013), or
    b. successfully complete the online component of the BCPhA OAT-CAMPP training program, and
    c. record self-declaration of training completion in eServices.
3. Pharmacy managers must:
    a. educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to opioid agonist treatment, and
    b. document the completion of the education of individual non-pharmacist staff members on a form signed and dated by the pharmacy manager and the non-pharmacist staff member, and retain the completed forms in the pharmacy's files.

Effective March 31, 2021:

The CPBC MMT training program (2013) will not be available beyond March 31, 2021. Registrants will no longer be able to fulfill the College's training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by March 31, 2021. The above-noted Policy Statements 1a and 2a will be repealed and all other requirements will continue to be in effect.

During the period between January 1, 2019 and March 31, 2021, registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment are strongly encouraged to complete the OAT-CAMPP program as soon as practicable.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide* (2018) is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU*) A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.
2. The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs.

~~**The Methadone Maintenance Policy Statements must be read in conjunction with *PPP-71 Delivery of Methadone Maintenance Treatment*.**~~

Required References

In addition to the currently required pharmacy reference materials (*PPP-3*), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and subsequent revisions.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most current version of the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders.*
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

Appendix 5

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths and formulations.
2. The CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 Sep 2013 / 17 Nov 2017 / 20 Apr 2018 / 14 Sep 2018 / 23 Nov 2018
Reaffirmed:

Appendix 5

College of Pharmacists of British Columbia

Professional Practice Policy #66

Policy Guide

Buprenorphine/Naloxone Maintenance Treatment (2018)

Buprenorphine/Naloxone Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment (BMT) must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC (CPBC) *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily dispense (i.e., 7 days per week) the pharmacy hours of service need to accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for buprenorphine/naloxone maintenance treatment from 'daily dispense' to a 'take-home' dose.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take buprenorphine/naloxone tablets.

Guideline: For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. Avoid swallowing, talking, eating, drinking, and smoking.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, cravings, and/or non-medical opioid use. Educate on risks of precipitated withdrawal during buprenorphine/naloxone induction. Educate patients on the inclusion of naloxone in buprenorphine/naloxone formulations and its purpose to deter use in a manner not intended as prescribed.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*. Recommend completion of online training through the University of British Columbia, Faculty of Medicine Continuing Professional Development's *Provincial Opioid Addiction Treatment Support Program*.

2.0 Receiving Buprenorphine/Naloxone Prescriptions

2.1 Controlled Prescription Program Forms - Overview

Principle 2.1.1 Buprenorphine/naloxone prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting buprenorphine/naloxone prescriptions, the pharmacist must ensure that the Controlled Prescription Program f~~F~~orm is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) Buprenorphine/Naloxone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Buprenorphine/naloxone for maintenance must be dispensed to patients as an approved, commercially available formulation.

Guideline: Buprenorphine/naloxone is currently available in multiple strengths of sublingual formulations. Tablets can be halved and/or combined to achieve target doses.

Principle 3.1.2 Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g., weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily dispense, take-home doses), including the specific days of the week for each dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of buprenorphine/naloxone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the buprenorphine/naloxone maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the buprenorphine/naloxone maintenance program. Co-ingestion of buprenorphine/naloxone with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing Buprenorphine/Naloxone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the buprenorphine/naloxone prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a buprenorphine/naloxone prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a buprenorphine/naloxone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *Buprenorphine/Naloxone Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

College of Pharmacists of British Columbia

Principle 4.1.4 If a prescriber orders the buprenorphine/naloxone for daily dispense, the pharmacist is not required to observe the patient ingesting the dose. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: If the prescription states daily dispense, the patient may ingest the dose without pharmacist observation.

Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. The patient should avoid swallowing, talking, eating, drinking, and smoking.

Principle 4.1.5 If a prescriber orders the buprenorphine/naloxone to be dispensed as a 'Daily Witnessed Ingestion' or 'DWI', the pharmacist must directly observe the patient placing the medication under the tongue. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves - this may take up to 10 minutes. The patient should avoid swallowing, talking, eating, drinking, and smoking.

The patient is not required to remain in the pharmacy once the pharmacist has directly observed the patient placing the medication under the tongue.

Principle 4.1.6 If take home doses (carries) are prescribed, the first dose does not need to be witnessed, unless ordered by the prescriber. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Compliance packaging (e.g., blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy must still ensure that the medications are provided in child-resistant packaging.

Patients should be reminded that buprenorphine/naloxone should be stored out of the reach of children, preferably in a locked cupboard or small lock box.

5.0 Responding to Buprenorphine/Naloxone Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any buprenorphine/naloxone prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up buprenorphine/naloxone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses before the next scheduled release of medication. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for this purpose.

Principle 5.1.4 If a patient misses 6 or more consecutive days, the prescription must be cancelled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder* - Appendix 2: Induction and Dosing Guidelines for Buprenorphine/Naloxone.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the documentation and communication.

The *Buprenorphine/Naloxone Part-Fill Accountability Log* (Appendix 1) can be used for the Part-Fill Accountability Log.

5.3 Lost or Stolen Doses

Principle 5.3.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Tapering

Principle 5.4.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

Buprenorphine/Naloxone Part-Fill Accountability Log

Patient Name:

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Patient Name:

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their buprenorphine/naloxone dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

College of Pharmacists of British Columbia

Appendix 5

College of Pharmacists of British Columbia

Professional Practice Policy #66

Policy Guide

Methadone Maintenance Treatment (2013)

Forward

Opioid dependence is a health concern with implications for the individual patient as well as the public. Methadone maintenance treatment is recognized internationally as among the most effective treatments for opioid use disorder (OUD). Addiction treatment experts recommend that methadone treatment for OUD be delivered with a maintenance-oriented, rather than abstinence-oriented, philosophy. This approach acknowledges OUD as a chronic disease.

Many studies, conducted over several decades in different countries, have clearly demonstrated that the effective delivery of methadone maintenance treatment reduces non-medical opioid use, other problematic substance use, criminal activity, mortality, injection-related risks and transmission of blood-borne disease. Additional positive results are improvement in physical and mental health, social functioning, quality of living and pregnancy outcomes.

Methadone, a long-acting, orally effective opioid, is used as a substitute for heroin or other narcotics when treating opioid dependence. Methadone eliminates withdrawal from and reduces cravings for, opioids. Methadone does not produce euphoria, and it blocks the euphoric effects of other opioids. When used in the treatment of opioid dependence, a single oral dose of methadone is effective for at least 24 hours. Eventual withdrawal from methadone is not necessarily the goal of the program, although some individuals may work with their physician and pharmacist to decrease their dose and eventually stop using methadone.

Methadone prescribing is controlled by both federal and provincial legislation, as well as administrative procedures and guidelines.

Registered pharmacists are permitted to purchase and dispense methadone without federal exemption. However, the College of Pharmacists of BC (CPBC) *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* requires that the pharmacy manager and all staff pharmacists employed in a community pharmacy that provides services related to methadone maintenance treatment complete the *CPBC Methadone Maintenance* Treatment (MMT) or the British Columbia Pharmacy Association's (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and any subsequent updates. You must log into eServices to complete the "*Declaration of Completion and Understanding*" prior to providing methadone maintenance treatment services.

How to Use This Guide

This Policy Guide (the Guide) is a companion to *Professional Practice Policy (PPP-66) –Opioid Agonist Treatment* (Appendix 1). The intention of the *Guide* is to provide pharmacists with further detail and clarity (including practical examples) to assist in the implementation of the policy into practice to ensure consistency in the safe and effective delivery of methadone maintenance treatment services.

As always the expectation is that pharmacists will practice in compliance with their legislative requirements, including the principles outlined in this *Guide*. It is understood however that pharmacy practice is not always 'black and white' and when navigating the 'grey' pharmacists must use sound professional judgment, ensuring that their decisions are made in the best interest of the patient and with appropriate collaboration, notification and most importantly, documentation.

The *Guide* is to be read in conjunction with completion of the mandatory training session. Information regarding the mandatory sessions can be found on the CPBC website at **www. bcpharmacists.org.**

Note:
This document is not intended to cover all possible practice scenarios.

Declaration

After completing the mandatory training program, and subsequently reading this *Guide*, pharmacists must log into eServices to complete the '*Declaration of Completion and Understanding*'.

Acknowledgement

The development of this *Guide* involved a collaborative and consultative process with input and feedback gathered from a volunteer group of dedicated community pharmacists currently engaged, in varying capacities, in the delivery of methadone maintenance treatment services.

The group was comprised of both frontline pharmacists and pharmacy managers and represented a cross-section of practice types (independent to large chain retailers) and practice settings including pharmacies located in Vancouver's Downtown Eastside whose primary focus is on the provision of methadone maintenance treatment.

Feedback was also solicited from other stakeholder groups including; the Ministry of Health Services, the College of Physicians and Surgeons of BC, the BCPhA, the City of Vancouver, patient advocacy groups Vancouver Area Network of Drug Users (VANDU), and the BC Association for People on Methadone (BCAPOM).

The College of Pharmacists of BC would like to sincerely thank each of these individuals and organizations for their invaluable feedback in the creation of this significant resource for pharmacists.

Feedback

Questions and comments about this *Guide* are welcome and can be sent to:
College of Pharmacists of British Columbia Telephone: 604-733-2440 or 800-663-1940

200 – 1765 West 8th Avenue Facsimile: 604-733-2493 or 800-377-8129
Vancouver, BC V6J 5C6 E-mail: practicesupport@bcpharmacists.org
Web site: www.bcpharmacists.org

Methadone Maintenance Treatment Policy Guide

In accordance with *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* (Appendix 1), all pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must know and apply the principles and guidelines outlined here in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions. The responsibility of pharmacy technicians in the dispensing of MMT is consistent with their scope of practice outlined in the *Health Professions Act* (HPA) Bylaws Schedule F Part 1 section 4.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 ~~Patients must attend the pharmacy unless exceptional circumstances are provided for under *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*~~ The pharmacy hours of service must be consistent with the supervised dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily witness ingestion (i.e., 7 days per week) the pharmacy hours of service must accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for methadone maintenance treatment from 'daily witness' to a 'take-home' dose.

1.2 Privacy and Confidentiality – Premise

Principle 1.2.1 All pharmacies offering methadone maintenance treatment must be in compliance with all relevant legislation pertaining to the structure of the licensed premise with particular attention given to ensuring there is sufficient space to accommodate patients waiting for witnessed ingestion and/or take home methadone doses while simultaneously maintaining privacy for pharmacist-patient consultation.

Guideline: It may be appropriate to establish a staggered schedule for regular patients requiring witnessed ingestion to ensure that there is

adequate space within the pharmacy to accommodate patients who are waiting and ensure privacy of pharmacist-patient consultation.

1.3 Security – Premise

Principle 1.3.1 All pharmacies offering methadone maintenance treatment must ensure that their pharmacy is in compliance with all relevant legislation pertaining to pharmacy security requirements including those outlined in *Professional Practice Policy (PPP-74) – Community Pharmacy and Telepharmacy Security*.

2.0 Receiving Methadone Prescriptions

2.1 ~~Methadone Maintenance~~ Controlled Prescription Program Forms – Overview

Principle 2.1.1 Methadone maintenance prescriptions can only be accepted when written using an original approved ~~Methadone Maintenance~~ Controlled Prescription Program form.

Guideline: When accepting a methadone maintenance prescription written on the Methadone Maintenance Controlled Prescription form, a pharmacist must ensure that ~~the Methadone Maintenance Controlled Prescription~~the form is completed by the prescriber as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3).

Principle 2.1.2 The pharmacist must ensure that the patient, as well as themselves, sign the form, in the space indicated on the bottom of the form.

Principle 2.1.3 Faxed ~~Methadone Maintenance~~ Controlled Prescription Program forms are not acceptable unless under extenuating circumstances where the prescriber has determined, following consultation with the pharmacist, that the urgency of the situation warrants it.

Guideline: In such cases the pharmacy, prior to dispensing the medication, must receive, in addition to a fax of ~~the~~ an ~~Methadone Maintenance~~ approved Controlled Prescription Program form, written confirmation (fax acceptable) signed by the prescriber that briefly describes the emergency situation and guarantees the delivery of the original ~~Methadone Maintenance~~ approved Controlled Prescription Program form to the pharmacy the next business day or as soon as possible when the prescriber is not available.

The faxed ~~Methadone Maintenance~~ approved Controlled Prescription Program form and related documentation, as described in Appendix 4, must be attached to the original ~~Methadone Maintenance~~ Controlled Prescription Program form once received.

Note: The *Emergency Fax Controlled Prescription Program Form Documentation* (Appendix 4) can be used for this purpose.

Principle 2.1.4 In an effort to maximize the effectiveness of the methadone maintenance treatment program, the pharmacist may find it beneficial to engage in a specific dialogue with the patient, either when they initiate treatment or at various times throughout treatment, that clearly outlines the expectations of both the patient and the pharmacist.

Guideline: The *Methadone Maintenance Treatment Expectation Form* (Appendix 5) can be used for this purpose.

Principle 2.1.5 In the rare circumstance (disruptive or threatening behavior or verbal or physical abuse) where a pharmacist finds that they must terminate the pharmacist-patient relationship, reasonable notice must be provided to the patient to ensure their continuity of care.

Guideline: It is important to remember that the decision to terminate a pharmacist-patient relationship is a serious one and must be made with due consideration and based on appropriate rationale. It is unethical for a pharmacist to terminate the pharmacist-patient relationship or refuse to treat a patient on morally irrelevant grounds. The pharmacist's decision should be documented and retained in the patient record.

2.2 ~~Methadone Maintenance~~ Controlled Prescription Program Forms – Alterations

Principle 2.2.1 Alterations to the ~~Methadone Maintenance~~approved Controlled Prescription Program form are the exception to the rule and should not be normal practice as they increase the likelihood of errors and drug diversion and put the public at risk. In the rare circumstance when an alteration is necessary to ensure the continuity of care pharmacists must always use due diligence to ensure authenticity and accuracy of the prescription.

Guideline:
Alterations completed at the prescriber's office: Alterations are only permitted on the sections of the form that the prescriber completes provided that the prescriber has initialed the alteration. Alterations are not permitted to the pre-printed sections of the form.

Alterations completed at the pharmacy: Pharmacists do not have independent authority to make any alterations or changes to the approved~~a Methadone Maintenance~~ Controlled Prescription Program form. Any required or requested change(s) must be patient-specific and authorized by the patient's prescriber through direct consultation with the pharmacist. Any prescriber-authorized changes must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication whenever possible and attached and filed with the original prescription.

Note: The *Pharmacist-Prescriber Communication Form* (Appendix 4) can be used for this purpose.

2.3 Out-of-Province Prescriptions

Principle 2.3.1 Pharmacists are permitted to dispense methadone prescriptions from prescribers in provinces other than BC.

Guideline: If there are any doubts regarding the authenticity of the out-of-province prescription, the pharmacist must contact the out-of-province prescriber to confirm the legitimacy of the prescription. When satisfied that the prescription is authentic, the pharmacist can dispense and process the

prescription in the same manner as other prescriptions from out-of-province prescribers.

Note: It's important to realize that not all provinces are required to use Controlled Prescription Program forms.

3.0 Processing (Dispensing) Methadone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Methadone for maintenance must be dispensed to patients in a concentration of 10 mg/ ml.

Guideline: Only commercially available 10 mg/ml oral preparations are permitted for use.

Principle 3.1.2 Positive identification is required for all patients presenting a prescription for the first time, and reasonable steps to positively identify the patient must be taken prior to dispensing any subsequent prescriptions.

Guideline: The CPBC *Professional Practice Policy (PPP-54) – Identifying Patients ~~for PharmaNet Purposes~~and Patient Representatives in Community Pharmacy and Telepharmacy Settings* provides guidance for registrants on taking reasonable steps to confirm the identity of patient. ~~requires the pharmacist to view one piece of "primary identification" or two pieces of "secondary identification" as verification of a positive identification. If a patient cannot provide the required identification,~~ T~~t~~he prescriber may be contacted to assist with verifying the patient's identity, if necessary.~~.~~

Principle 3.1.3 Pharmacists and pharmacy technicians must review the prescription to ensure that it is completed by the prescriber as outlined in the Controlled Prescription Program, ~~as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3)~~ and that the directions for use appropriately meet the specific needs of the patient and can be accommodated by the pharmacy. If the prescription is written using the Methadone Maintenance Controlled Prescription Form, it should be completed by the prescriber as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3).

Guideline: Each prescription must be reviewed in detail in consultation with, and consideration given to the specific needs of, the patient. The following list is a sample only:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a weekend when the patient will not be able to see a prescriber for a new prescription.
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, divided dose, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.
- Confirm that stamped or preprinted sticker directions do not conflict with written directions.

Any ambiguous or conflicting information identified must be clarified with the prescriber. Should an alteration or change to the prescription be required, it must be done in compliance with the Principles and Guidelines outlined in section 2.2.

3.2 Assessment of a Prescription

Principle 3.2.1 Pharmacists and pharmacy technicians must correctly identify the product as prescribed ‘for pain’ or ‘for opioid use disorder’ by using the appropriate Drug Identification Number (DIN) or Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

Principle 3.2.2 As with all medications a pharmacist **must** review each individual PharmaNet patient record, as stated in *HPA Bylaws* (Schedule F Part 1), and resolve any drug-related problems prior to dispensing any methadone prescription. This step is particularly critical for methadone prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system does not include methadone. Pharmacists providing methadone maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to methadone. General information in this regard can be found in Appendix 7.

Guideline: A PharmaNet patient record review must be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3 Mood altering drugs, including benzodiazepines and narcotics, are not generally prescribed to patients on the methadone maintenance program. Should a patient present a prescription for a mood altering drug or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of methadone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the methadone maintenance program.

Guideline: The pharmacist should document the outcome of the consultation(s) with the prescriber(s) and attach it to the original prescription.

Principle 3.2.4 The 'sig field' on the prescription label must include the start and end dates of the original current prescription.

Principle 3.2.5 As required by *HPA Bylaws* Schedule F Part 1 the 'dispensing date' on the prescription label must accurately reflect the actual date dispensed on the PharmaNet system.

3.3 Preparing Methadone Prescriptions

Principle 3.3.1 Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 ml.

Guideline: All devices used to measure the methadone 10 mg/ml solutions should be distinctive and recognizable and must be used only to measure methadone solutions. Devices must be labeled with a 'methadone only' label and a 'poison' auxiliary label with the international symbol of the skull and cross bones.

Principle 3.3.2 Reconciliation procedures must be conducted in accordance with *Professional Practice Policy (PPP-65) – Narcotic Counts and Reconciliations*.

Guideline: ~~As per *PPP-65*, the pharmacy manager must ensure that narcotic counts and reconciliations, which include methadone, are completed:~~
~~At a minimum of every 3 months,~~
~~After a change of manager, and~~
~~After a break-in or robbery.~~

Reconciliation means the quantity of methadone on hand must equal the quantity received minus the quantity dispensed over a specific period of time.

3.4 Loss or Theft and Disposal of Methadone

Principle 3.4.1 The *Narcotic Control Regulations* require that pharmacists report the loss or theft of controlled drugs and substances to the Office of Controlled Substances, Health Canada within 10 days of the discovery of the loss or theft. In the event of a loss or theft the pharmacy should also notify the CPBC ~~as soon as possible.~~within 24 hours.

Guideline: The form for reporting loss or theft of narcotics can be found on the CPBC website www.bcpharmcists.org under *Resources.*

Principle 3.4.2 Methadone, like any other narcotic or controlled drug, can only be disposed of with authorization from Health Canada and after being rendered unusable.

Guideline: To receive authorization to dispose of methadone the pharmacist must submit a written *Authorization to Destroy for Expired Narcotic and Controlled Drugs* to the Office of Controlled Substances, Health Canada.

An acceptable method of rendering methadone unusable is to place the product in a leak-proof container or plastic bag and add kitty litter until the mixture is almost solid.

Once the required authorization is received from Health Canada the pharmacist must record the amount of product to be disposed of, having a second healthcare professional sign for the disposal, and place the now rendered unusable product in the pharmacy's medication return container.

3.5 Methadone in Tablet Form for Air Travel

Principle 3.5.1 Hand luggage restrictions governing the transportation of fluids in air travel may be problematic for patients and in certain circumstances may necessitate the prescription of methadone in tablet form. Only commercially available methadone in tablet form may be dispensed. Pharmacists need to be aware that the prescription of methadone in tablet form may result in increased risk for both patients and the public. **Note**: Dispensing of methadone powder by way of sachet, capsule, or other format is never acceptable due to the increased potential for diversion and misuse.

Guideline: Long-term methadone maintenance treatment clearly limits patients' ability to travel because of the need for regular follow-up as well as the restrictions associated with the dispensing of methadone. If patients receiving MMT wish to travel for a period of time that exceeds their regular carry period, the usual standard of care should not be compromised, particularly if the patient is not stable and still requires daily supervised ingestion.

Patients are significantly limited in their ability to transport methadone across international borders but it is possible to arrange for methadone dispensing in some jurisdictions. The CPSBC advises physicians to research

each case to ensure decisions do not compromise patient safety. In some cases, patients may require documentation for the purpose of crossing international borders or to assist in accessing temporary care from a methadone program at their destination. The physician is responsible to provide the required travel documentation.

4.0 Releasing Methadone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present and witness the release of a methadone prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a methadone prescription the pharmacist must assess the competence of the patient (i.e. ensure that the patient is not currently intoxicated or otherwise mentally impaired) to ensure that it is safe to release the medication to them.

Guideline: Pharmacists must assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's 'normal' behaviour in order to be able to detect significant deviations from normal.

If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and attach it to the original prescription.

Principle 4.1.3 Prior to releasing a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log (the sample *Methadone Part-Fill Accountability Log* (Appendix 9) can be used for this purpose).

Guideline: Every part-fill dispensed must be accounted for. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

The pharmacist releasing and the patient receiving the part-fill of the prescription must sign for each witnessed ingestion dose and each take-home dose. **Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.**

The patient/prescription specific log (the sample *Methadone Part-Fill Accountability Log* (Appendix 9) can be used for this purpose) must be attached to the original Controlled Prescription Program form and once complete filed sequentially by the first prescription or transaction number assigned to the prescription.

Principle 4.1.4 As with all prescriptions, prior to releasing a methadone prescription, the pharmacist must counsel the patient on the risks (including common side effects) and benefits of taking their medication as per *HPA Bylaws* Schedule F Part 1 section 12.

Guideline: The most common adverse reactions with methadone include; sweating, constipation, sexual dysfunction, change in menstruation, drowsiness, sleep disturbances, muscle and bone aches, weight changes (usually gain), skin rash, gastrointestinal upset, headaches and edema. Patients will benefit from information about the non-drug approaches, non-prescription products and prescription items that can provide relief from these side effects.

Principle 4.1.5 With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

Guideline: Given the concentrated solution of 10mg/ml, it may be helpful to provide a glass of water to the patient to enable rinsing out of the dispensing container to ensure full dose administration.

Immediately following observing the patient's ingestion of the medication the pharmacist should engage the patient in a short conversation to ensure that the entire dose has been swallowed.

Principle 4.1.6 With respect to take-home doses the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion with all subsequent take-home doses dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient.

Guideline: Each dose must be dispensed in an individual, appropriately sized, child-resistant container.

Each container must be individually labeled.

If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses it must be documented on the patient record.

Patients should be reminded that methadone should be stored out of the reach of children, preferably in a locked cupboard or small lock box if stored in the refrigerator.

Note: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Principle 4.1.7 In extraordinary situations, when a patient cannot attend the pharmacy, the patient's representative may pick up and sign for their authorized take-home dose(s) if confirmed in writing by the prescriber.

Guideline: This authorization must be date specific, and the representative and circumstances must be clearly defined. The written and signed authorization from the prescriber (fax acceptable) must be attached to the original approved ~~Methadone Maintenance~~ Controlled Prescription Program form.

Note: Patient representative is defined in *HPA Bylaws*.

~~**Principle 4.1.8** Delivery of methadone is **prohibited** under federal legislation except as provided for in extraordinary circumstances according to *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*~~

~~**Guideline:** The pharmacist must read and understand *Professional Practice Policy (PPP- 71) – Delivery of Methadone Maintenance Treatment.*~~

5.0 Responding to Methadone Dosing Issues

5.1 Divided (Split) Doses

Principle 5.1.1 Only the prescriber, by stating this on the original approved ~~Methadone Maintenance~~ Controlled Prescription Program form, can authorize a divided (split) dose of a prescription. Unless otherwise specified by the prescriber, the first portion of the daily dose must be by witnessed ingestion.

Guideline: The decision to authorize a divided dose can only be made by the prescriber, however, should a pharmacist believe that a patient would benefit from this they should discuss this option with the prescriber.

5.2 Missed Doses

Principle 5.2.1 Any methadone prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet before the end of the business day.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up methadone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.2.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.2.3 The pharmacist must notify the prescriber of any missed doses (unless a specified number of missed doses has been indicated by the prescriber) before the next scheduled release of medication.

Guideline: The notification document must be retained and filed with the prescription consistent with filing retention requirements. The *Pharmacist-Prescriber Communication Form* (Appendix 6) can be used for this purpose.

5.3 Partial Consumption of Doses

Principle 5.3.1 If a patient refuses to consume their full dose, the pharmacist must not insist that they ingest the total amount. The unconsumed portion however cannot be given as a take-home dose.

Guideline: The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. *The Pharmacist-Prescriber Communication Form* (Appendix 6) can be used for this purpose.

All patient documentation including the *Methadone Part-Fill Accountability Log* (Appendix 9) and PharmaNet record must accurately reflect the actual dose consumed by the patient.

5.4 Vomited Doses

Principle 5.4.1 If a patient reports that they vomited their dose, a replacement dose cannot be provided without authorization from the patient's prescriber.

Guideline: The pharmacist must contact the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). Should the prescriber authorize a replacement dose, it must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication and attached and filed with the original prescription.

5.5 Lost or Stolen Doses

Principle 5.5.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided without authorization from the patient's prescriber.

Guideline: The pharmacist must contact the prescriber and discuss the situation with them. Should the prescriber determine that the situation warrants it they may authorize the acceptance of a new approved ~~Methadone Maintenance~~ Controlled Prescription Program form by fax (refer to Principle 2.1.3) or the prescriber may advise the pharmacy that they must wait until the patient presents a new original approved ~~Methadone Maintenance~~ Controlled Prescription Program form.

5.6 Tapering

Principle 5.6.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/ prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication Form* (Appendix 6) can be used for the purpose of notifying the prescriber.

5.7 Emergency Dosing

Principle 5.7.1 Emergency dosing is not recommended. If however a pharmacist feels in their professional judgement that an emergency dose is required to ensure continuity of patient treatment the pharmacist may provide an emergency dose. The pharmacist must counsel the patient to obtain a new prescription as soon as possible. This practice is the exception to the rule and not the normal practice, refer to *Professional Practice Policy (PPP-31) – Emergency ~~Prescription Refills~~Supply for Continuity of Care*.

Guideline: Pharmacists need to document, as per *PPP-31*, the attempt to reach the prescriber with information about the situation. The prolonged half-life of methadone ensures that a patient maintains a single dose for at least 36 hours. Although the patient may feel uncomfortable an emergency

dose may not be necessary. Emergency doses may hinder treatment success and health outcomes. It is a patient's responsibility to make sure they have a valid prescription.

6.0 Continuity of Care

6.1 Transfer of Pharmacy

Principle 6.1.1 When a patient chooses to move from one pharmacy to another to receive their methadone prescription it is the responsibility of the new pharmacy to contact the previous pharmacy and prescriber (if applicable) to discuss the exact transfer date and any other pertinent concerns. The previous pharmacy must cooperate fully with the request from the new pharmacy.

Guideline: Communication between the previous and new pharmacy is critical to ensure the patient's continuity of care and to avoid duplicate or missed methadone doses. A review of the patient's PharmaNet patient record can be of assistance in determining the previous pharmacy and prescriber.

6.2 Hospitalization or Incarceration

Principle 6.2.1 When a patient is discharged or released to the community from a hospital or correctional facility it is the responsibility of the community pharmacist receiving the patient to verify the date and amount of the last dose administered.

Guideline: Effective communication sharing among those who provide the patient's methadone maintenance treatment (hospital or correctional facility and pharmacy) is essential to ensure the patient's continuity of care and to avoid duplicate or missed methadone doses.

6.3 Compounding in Exceptional Circumstances

Principle 6.3.1 The only situation that would constitute consideration of exceptional circumstances is when a commercially available 10 mg/ml oral preparation is not available.

Principle 6.3.2 Methadone for maintenance must be at the strength of 10 mg/ml to ensure minimization of errors.

Principle 6.3.3 A compounding log must be established to record when methadone solutions are prepared, how much was prepared, and who prepared the product. The *Compounding Log* (Appendix 8) can be used for this purpose.

Guideline: The compounding log must incorporate the following elements:

- Preparation date,
- Methadone powder and/or liquid concentrate manufacturer's lot number and expiry date,
- Methadone powder and/or liquid concentrate quantity used and quantity prepared,
- Batch number and use-by date assigned by the pharmacy, and
- Preparer's and pharmacist's identification.

A separate compounding log must be maintained for each strength of stock solution

Principle 6.3.4 All concentrated solution containers must be clearly labeled with the drug name, strength, use-by date and appropriate warning labels.

Guideline: If different concentrations are prepared for pain management, they must be easily identifiable with clear labeling. A best practice would be to use different styles of storage container for each concentration or use food grade dyes to differentiate between the different concentrations prepared.

In order to help ensure liquid methadone preparations remain stable for up to 30 days from the date of pharmacy dispensing and to minimize the growth of bacteria, mold and fungus the *American Association for the Treatment of Opioid Dependence* recommends that pharmacists should:

- Use distilled water for the dilution of methadone products,
- Use new, clean, light-resistant containers for dispensing,
- Refrigerate take-home containers as soon as possible and keep refrigerated until used.

Principle 6.3.5 Methadone for maintenance solutions must be made with full-strength Tang™ or similar full-strength beverage crystals with daily doses (witnessed ingestion or take-home). Plain water is never an acceptable vehicle for dispensing to patients in the methadone maintenance treatment program.

Guideline: The beverage crystals are full-strength when made according to the manufacturer's directions found on the product's packaging.

Dispensing as a standard volume (e.g., all doses dispensed as a volume of 100 mL) is not acceptable.

Appendix 1

CPBC Professional Practice Policy PPP-66 – Opioid Agonist Treatment

See the most up-to-date Professional Practice Policy – 66 Opioid Agonist Treatment on the CPBC website: http://library.bcpharmacists.org/6_Resources/6-2_PPP/5003-PGP-PPP66.pdf

~~This policy provides guidance to registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment.~~

~~**Policy statements:**~~

~~Effective January 1, 2019:~~

1. ~~All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:~~
    a. ~~successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or~~
    b. ~~successfully complete the British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and~~
    c. ~~record self-declaration of training completion in eServices.~~
2. ~~All pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:~~
    a. ~~successfully complete the CPBC MMT training program (2013), or~~
    b. ~~successfully complete the online component of the BCPhA OAT-CAMPP training program, and~~
    c. ~~record self-declaration of training completion in eServices.~~
3. ~~Pharmacy managers must:~~
    a. ~~educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to opioid agonist treatment, and~~
    b. ~~document the completion of the education of individual non-pharmacist staff members on a form signed and dated by the pharmacy manager and the non-pharmacist staff member, and retain the completed forms in the pharmacy's files.~~

~~Effective March 31, 2021:~~

~~The CPBC MMT training program (2013) will not be available beyond March 31, 2021. Registrants will no longer be able to fulfill the College's training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by March 31, 2021. The above-noted Policy Statements 1a and 2a will be repealed and all other requirements will continue to be in effect.~~

~~During the period between January 1, 2019 and March 31, 2021, registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment are strongly encouraged to complete the OAT-CAMPP program as soon as practicable.~~

~~1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:~~

1. ~~Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.~~
2. ~~The CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide* (2018) is in force.~~
3. ~~All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment must:~~
    a) ~~know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,~~
    b) ~~be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU*) A Guideline for the Clinical Management of Opioid Use Disorder*, and~~
    c) ~~be familiar with the information included in the product monographs of approved, commercially available formulations.~~

~~2. Methadone Maintenance Policy statements:~~

1. ~~Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.~~
2. ~~The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.~~
3. ~~All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must:~~
    a) ~~know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,~~
    b) ~~be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and~~
    c) ~~be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs.~~

The Methadone Maintenance Policy Statements must be read in conjunction with *PPP-71 Delivery of Methadone Maintenance Treatment*.

Required References

In addition to the currently required pharmacy reference materials (*PPP-3*), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and subsequent revisions.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most current version of the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders.*
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths and formulations.
2. The CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

Appendix 5

Appendix 2

CPBC Professional Practice Policy PPP-71 – Delivery of ~~Methadone Maintenance~~Opioid Agonist Treatment

See the most up-to-date Professional Practice Policy – 71 Delivery of Opioid Agonist Treatment on the CPBC website: http://library.bcpharmacists.org/6_Resources/6-2_PPP/5003-PGP-PPP71.pdf.

~~POLICY STATEMENT(S):~~

~~Under extraordinary circumstances, if the patient has restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of methadone for maintenance. This practice is the exception to the rule and not normal practice.~~
~~Neither the pharmacy manager nor the staff pharmacist may authorize the provision of home delivery for methadone in the absence of the prescriber's authorization on the prescription.~~

~~Delivery Standards:~~

~~1. Prescribing Physician Authorization of Home Delivery~~

~~a. Should the prescribing physician determine that, due to the patient's immobility, delivery is required; the physician may authorize delivery by signing the declaration on the Methadone Maintenance Program, Controlled Prescription Program form.~~
~~i. If the pharmacist or pharmacy technician has concerns regarding the authenticity of the prescriber's signature they must contact the prescriber for verification.~~
~~ii. Physicians will not authorize delivery unless patient safety is assured and restrictions in mobility have been identified.~~
~~iii. Distance between patient home and pharmacy does not qualify as a restriction in mobility.~~

~~2. Home Delivery Schedule and Location~~

~~If delivery is authorized as noted in section 1 above, the pharmacist must meet the following delivery requirements:~~
~~a. The pharmacist must determine whether home delivery is feasible within the services and resources the pharmacy provides. If the pharmacy does not provide delivery service – it may be appropriate to refer the patient to a pharmacy that can provide the delivery.~~
~~b. If the pharmacy is able to provide home delivery the pharmacist must work with the patient to make appropriate arrangements for delivery. Arrangements must include:~~
~~i. Address for delivery - methadone may only be delivered to a patient's home with a valid street address; delivery to a public location is not permitted.~~
~~ii. Time for delivery.~~
~~iii. Procedure if patient not available at address to receive methadone delivery including communication of appropriate alternate arrangements for the patient to obtain their prescription.~~
~~**Note:** ***It is not acceptable for the pharmacist to deliver the methadone to an alternate person or location or to leave the methadone unattended***.~~

~~3. Secure Transportation and Storage~~

a. The dispensing pharmacist is responsible for securely transporting and appropriately storing methadone.
b. Methadone must be transported directly from the dispensing pharmacy to the patient's home address; methadone may not be stored outside of the pharmacy under any circumstances.

4. Release of Methadone for Maintenance

The pharmacist must be present to:

a. Confirm the identity of the patient.
b. Assess the competence of the patient.
c. Witness the release and ingestion of methadone to the patient, this responsibility cannot be delegated to a pharmacy technician or any other pharmacy support staff.
d. Provide appropriate patient counseling.
e. If carries are provided, the pharmacist must always witness first dose of the take-home prescription; all subsequent doses must be dispensed in child-resistant containers with explicit warning label(s).

5. Documentation

The pharmacist must:

a. At the time of release of a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific part-fill accountability log. Neither party may 'pre-sign' for future doses.
b. Document any and all home deliveries of methadone in the patient's record.
c. Log the home delivery with the address where the delivery was made on the methadone part-fill accountability log.
d. Document any appropriate follow-up plan in the patient's record.
e. File the methadone part-fill accountability log with original methadone prescription form.

BACKGROUND:

Legislation

Federal legislation does not support delivery of narcotics. The Controlled Drugs and Substances Act (CDSA) defines the transport or delivery of narcotics as trafficking, the Narcotic Control Regulations (NCR) limit the transport of narcotics to licensed dealers only.

Controlled Drugs and Substances Act
***"Section 2 - Interpretation, Definitions*[1]**

"traffic" means, in respect of a substance included in any of Schedules I to IV,
(a) to sell, administer, give, transfer, ***transport***, send or ***deliver*** the substance"

Narcotic Control Regulations
***"Section 2 - Interpretation, Definitions*[2]**

"licensed dealer" means the holder of a licence issued under section 9.2.

***Dealers' Licenses and Licensed Dealers*[3]**

8. *(1) Subject to these Regulations, no person* ***except a licensed dealer*** *shall produce, make, assemble, import, export, sell, provide,* ***transport, send or deliver a narcotic****."*

Pharmacists are required to adhere to the CDSA and its regulations as well as the *Health Professions Act*, *Pharmacy Operations and Drug Scheduling Act* and their *Bylaws*. The College of Pharmacists and the College of Physicians and Surgeons recognize that there are extraordinary circumstances where due to temporary or permanent restrictions in mobility patients would require delivery of their methadone for maintenance to ensure best patient health outcomes and continuity of care.

1 http://laws-lois.justice.gc.ca/eng/acts/C-38.8/page-1.html#h-2
2 http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-1.html#docCont
3 http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-3.html#docCont

Appendix 3

Methadone for Maintenance Controlled Prescription Form Guidelines

Methadone prescriptions can only be accepted when written using an original Methadone Maintenance Controlled Prescription form. When accepting a Methadone Maintenance Controlled Prescription form a pharmacist must ensure that the form is completed by the prescriber as outlined in these guidelines.

Methadone Maintenance Controlled Prescription Form (Example; Figure 1):

These duplicate copy prescriptions are pre-printed with the following information; drug name and strength, prescriber's name, address (optional), College ID number and prescription folio number. These prescription forms are used only for prescribing methadone for maintenance.

Top Section of Form:

The prescriber must complete in full, the patient information including; personal health number (PHN), name, address and date of birth. The 'prescribing date' indicates the date that the prescriber saw the patient. The 'Drug Name and Strength' section is preprinted and the prescriber must complete the 'Quantity' section by stating the total quantity of the prescription in numeric and alpha forms.

Under extraordinary circumstances, if the patient has severe restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of Methadone Maintenance Treatment (MMT). This practice is the exception to the rule and not normal practice. Refer to *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*

Note: If no 'start day' is indicated in the 'Directions for Use' section of the form the 'prescribing date' becomes the 'start day'.

Middle Section of Form:
The prescriber must complete the 'Directions for Use' section as follows:

- State the daily dose:
    - the daily dose multiplied by the number of days must equal the total quantity indicated on the prescription, if there is a discrepancy the pharmacist should seek clarification from the prescriber
- Indicate the 'start day' and 'last day':
    - if no 'start day' is indicated, the 'prescribing date' becomes the 'start day'
    - should the 'start day' overlap with, or leave gaps from, an existing prescription the pharmacist should seek clarification from the prescriber
- Indicate any special instructions:
    - may be used to provide special instructions to the pharmacist for example split doses, or special situations for carries.
- Indicate either DWI or CARRIES, if carries are indicated the prescriber must indicate both in numeric and alpha the required number of days per week of witnessed ingestion:
    - if neither of these options are circled the pharmacist is to assume that all doses are DWI
    - if CARRIES has been circled but the specific witnessed ingestion days (ex; Monday and Thursday) have not been noted by the prescriber the pharmacist can determine the days in consultation with the patient. However, the first dose of the prescription and the dose before any carries must be witnessed ingestion. Additionally, the witnessed ingestion doses must be spread evenly throughout the week
    - if CARRIES has been circled but the number of days per week of witnessed ingestion has been left blank the pharmacist must seek clarification from the prescriber

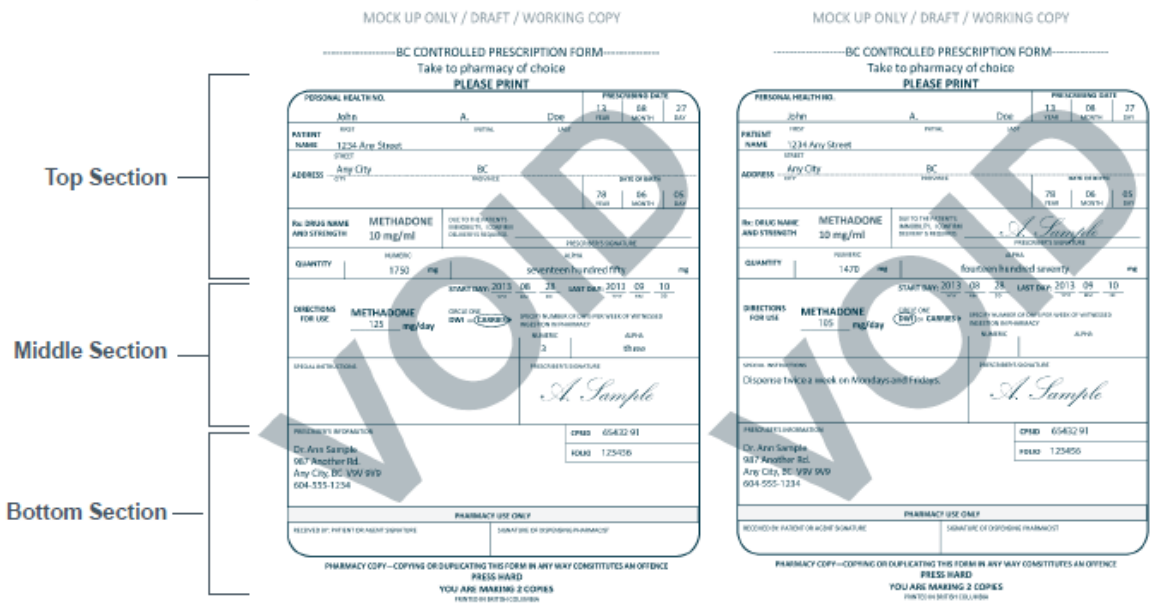
Note: "DWI except when pharmacy closed" is not an acceptable prescription instruction.

- Authorize the prescription by signing their name in the 'prescriber's signature' box

Bottom Section of Form:
As a minimum the prescriber's name, College ID number and prescription folio number will be pre-printed on the form. If the prescribers address is not pre-printed it must be completed by the pharmacist prior to dispensing the prescription. Both the patient and the pharmacist must sign the prescription in the appropriate box.

Note: A patient's representative signature is only acceptable with prior written authorization from the prescriber.

Figure 1: Methadone Maintenance Controlled Prescription Form



Appendix 4

Emergency Fax ~~Methadone Maintenance~~ Controlled Prescription Program Form Documentation

This form is for the use only in the event of an emergency that requires a faxed ~~Methadone Maintenance~~ Controlled Prescription Program form which has been initiated following direct consultation between the patient's pharmacist and prescriber.

It is understood that the pharmacist must obtain written documentation from the prescriber prior to dispensing any medication and as such is requesting that the prescriber complete this form and fax back to the pharmacy along with a fax of the ~~Methadone Maintenance~~ Controlled Prescription Program form as soon as possible.

Prescriber: _____ Patient Name: _____

Pharmacy: _____ Fax Number: _____

Pharmacist: _____ Date: _____

As the prescriber, I request that the above-named pharmacy accept a faxed transmission of the ~~Methadone Maintenance~~ Controlled Prescription Program form for the above-named patient. I understand that the ~~Methadone Maintenance~~ Controlled Prescription Program form must be faxed to and received by the pharmacy prior to the pharmacy dispensing methadone. I guarantee that the original ~~Methadone Maintenance~~ Controlled Prescription Program form will be sent to the pharmacy by the next business day.

Brief description of the emergency situation:

_____

_____

_____

_____

Prescriber's Name: _____

Prescriber's~~s~~CPS ID:

_____

Prescriber's Signature: _____

Signature Date: _____

Affix ~~Methadone Maintenance~~ Controlled Prescription Program form here

This form is for the use only in the event of an emergency that requires a faxed Methadone Maintenance Controlled Prescription form which has been initiated following direct consultation between the patient's pharmacist and prescriber.

It is understood that the pharmacist must obtain written documentation from the prescriber prior to dispensing any medication and as such is requesting that the prescriber complete this form and fax back to the pharmacy along with a fax of the Methadone Maintenance Controlled Prescription form as soon as possible.

Prescriber: _____ Patient Name: _____

Pharmacy: _____ Fax Number: _____

Pharmacist: _____ Date: _____

As the prescriber, I request that the above-named pharmacy accept a faxed transmission of the Methadone Maintenance Controlled Prescription form for the above-named patient. I understand that the Methadone Maintenance Controlled Prescription form must be faxed to and received by the pharmacy prior to the pharmacy dispensing methadone. I guarantee that the original Methadone Maintenance Controlled Prescription form will be sent to the pharmacy by the next business day.

Brief description of the emergency situation: _____

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Appendix 5

Methadone Maintenance Treatment Expectation Form

As your pharmacists, we believe in the principles of the methadone maintenance treatment program, and the valuable role it can play in improving people's lives and their health. We are committed to being an active member of your healthcare team and understand that the success of the program is dependent on ongoing collaboration and communication between yourself, ourselves and your prescriber.

To help you succeed in the program it is important that we both clearly understand the commitment and expectations of each other.

As your pharmacists, you can expect that we will:

- Treat you professionally and respectfully at all times.
- Make ourselves available to discuss any questions or concerns that you may have regarding the program.
- Provide methadone to you exactly as your prescriber has prescribed it and will ensure that they are made aware of any of the following:
    - Missed dose(s) for any reason (ie; failure to pick up, vomited, lost or stolen)
    - Less than full dose consumed (ie; tolerance, self-initiated tapering)
    - Presenting at the pharmacy while intoxicated
    - Prescribing of contraindicated medications (ie; mood-altering drugs)
- Not dispense your methadone (unless directed by your prescriber) to anyone other than you.
- Respect your choice (unless directed by your prescriber) of the pharmacy you wish to have dispense your medication.

As our patient, we can expect that you will:

- Treat all pharmacy staff and other patients respectfully at all times.
- Do your utmost to adhere to the methadone maintenance treatment program as prescribed to you.
- Discuss any concerns you may have regarding your methadone maintenance treatment with us or your prescriber prior to making any adjustments to treatment independently.
- Ensure that any take-home doses of methadone are stored safely and securely.
- Respect the pharmacy's greater community by refraining from loitering or littering.

Appendix 6

Pharmacist – Prescriber Communication

Date: _____ Patient Name: _____
To (Prescriber): _____ Patient PHN: _____
Fax: _____ Prescription Form Folio Number: _____
From (Pharmacy): _____ Pharmacy Fax: _____
Pharmacist: _____ Pharmacy Telephone: _____

For Prescriber's Information and Patient Records

❑ This patient missed their methadone dose _____ (dates).

❑ This patient did not take their full daily dose _____ (date) and consumed only ____mg of the ____ mg prescribed dose.

For Prescriber's Signature and Return of Form to Pharmacy

❑ We require clarity regarding the 'prescribing date' and/or 'start day' for the attached ~~Methadone Maintenance~~ Controlled Prescription Program form. Please indicate the actual 'prescribing date' (actual date the prescription was written) and dispensing 'start date' or range.

Prescribing Date: _____

Dispensing Start Date or Range: _____

❑ We require clarification and/or a change to the 'Direction for Use' section of the attached ~~Methadone Maintenance~~ Controlled Prescription Program form.

Description of authorized changes:

_____

_____

_____

_____

Prescriber's Name: _____

~~CPSID~~Prescriber ID:

_____

Prescriber's Signature: _____

Signature Date: _____

Affix ~~Methadone Maintenance~~ Controlled Prescription Program form here

College of Pharmacists of British Columbia

Appendix 5

Date: _____ Patient Name: _____

To (Prescriber): _____ Patient PHN: _____

Fax: _____ Prescription Form Folio Number: _____

From (Pharmacy): _____ Pharmacy Fax: _____

Pharmacist: _____ Pharmacy Telephone: _____

For Prescriber's Information and Patient Records

☐ This patient missed their methadone dose _____ (dates).

☐ This patient did not take their full daily dose _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.

For Prescriber's Signature and Return of Form to Pharmacy

☐ We require clarity regarding the 'prescribing date' and/or 'start day' for the attached Methadone Maintenance Controlled Prescription form. Please indicate the actual 'prescribing date' (actual date the prescription was written) and dispensing 'start date' or range.

Prescribing Date: _____

Dispensing Start Date or Range: _____

☐ We require clarification and/or a change to the 'Directions for Use' section of the attached Methadone Maintenance Controlled Prescription form.

Description of authorized changes: _____

_____

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Appendix 7

Drug Interactions – General Information

Methadone is extensively metabolized by cytochrome CYP3A4 in liver microsomes. Most drug interactions with methadone are associated with drugs that either induce or inhibit these enzymes.

The sequence of administration of the drugs is the key to evaluating the significance of the interaction. When a patient is stabilized on a drug that affects liver metabolism and methadone is introduced, the interaction may not be observed unless the first drug is discontinued. It is only if a patient is stabilized on methadone and an interacting drug is initiated or discontinued that an interaction may occur.

Drugs that may lower plasma levels (ie; increase the metabolism) of methadone include rifampin, barbiturates, phenytoin and carbamazepine. Drugs that may increase plasma levels (ie; decrease the metabolism) of methadone include ciprofloxacin and fluvoxamine.

Medications that might precipitate a withdrawal syndrome for patients on methadone must be avoided. These are mainly opioid antagonists such as pentazocine, butorphanol, nalbuphine, and naltrexone.

Pharmacists should not rely on PharmaNet to warn of a drug interactions for methadone. The use of PharmaNet is not intended as a substitute for professional judgment. Information on PharmaNet is not exhaustive and cannot be relied upon as complete. The absence of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective in any given patient. Health care professionals should confirm information obtained from PharmaNet, and ensure no additional relevant information exists, before making patient care decisions.

Appendix 8

Compounding Log

g/ml Stock Solution

Preparation Date	Manufac-turer's Lot Number (Powder)	Manufac-turer's Expiry Date (Powder)	Quantity Used (Powder)	Quantity Prepared (Solution)	Use-By Date (Solution)	Batch Number (Assigned by pharmacy)	Preparer's ID (Initials)	Pharmacist's ID (Initials)

Appendix 9

Methadone Part-Fill Accountability Log

Patient Name:

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Patient Name:

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Address if Applicable	Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Address if Applicable	Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Appendix 10

Methadone Information for Patients

What is methadone?

Methadone is a long-acting narcotic medication. Since the mid-1960s methadone has been used as an effective and legal substitute for heroin and other opiates. Methadone maintenance programs help opiate-dependent individuals stabilize their lives and reduce the harm associated with drug use.

How is methadone taken?

Methadone is prepared in a liquid. Doses are usually taken once a day as the effects of a single dose last for about one day. Your physician will write a prescription specifying your dose and how often you need to come to the pharmacy. Initially methadone is prescribed as a daily witnessed dose. As your treatment progresses you may be eligible for take-home doses.

How does methadone work?

Methadone is part of a long-term maintenance program for opiate or heroin dependent people. Drug cravings are reduced without producing a "high." The goal is to find the dose that will prevent physical withdrawal. The right dose will decrease your drug cravings, and help you to reduce or eliminate heroin use.

How long do I have to stay on methadone?

You should stay on methadone for as long as you experience benefits. Everyone responds differently and methadone can safely be taken for years. If you decide you want to stop taking methadone, you should discuss this with your physician.

Does methadone have side effects?

Methadone is usually tolerated well once the dose is stabilized. Most people experience few, if any, side effects. Please let your pharmacist or physician know if any of these symptoms are bothering you:

- Sweating – This can be due to the methadone itself, or a dose that is too high or too low.
- Constipation – Increasing exercise, fluids and fiber in your diet may decrease this problem.

- Sexual difficulties – This can be either a reduction or an increase in desire.
- Sleepiness or drowsiness – This may be caused by too much methadone. If this occurs consult your doctor to have your dose adjusted. Do not drive a car or participate in activities that require you to be alert when you are drowsy.
- Weight change – An increase in body weight may be due to better health and an improved appetite.

Can methadone interact with other drugs?

Yes. Alcohol and drugs, including prescription, nonprescription, herbal and street drugs, may interfere with the action of methadone in your body. Discuss all medications you are taking with your pharmacist or physician.

Is methadone dangerous?

Methadone is safe to use when it is prescribed and monitored by a physician. It can be very dangerous if used inappropriately. Methadone should never be taken by anybody except the person for whom it is prescribed as overdose and death can occur if the person is not dependent on opiates. Children are especially at risk for overdose and death if they swallow methadone accidentally.

What is my responsibility?

Your responsibility is to drink your methadone dose every day. If you have carries, you must make sure that they are stored safely to prevent possible ingestion by anyone else. If you store your carries in the fridge ensure that they are not accessible. Methadone can be very dangerous if used inappropriately so you must not give or sell your dose to anyone.

Will methadone cure me?

The methadone maintenance program can help you to make positive lifestyle changes. The goal of treatment is to stabilize your body physically and to provide an environment that supports you.

Appendix 5

College of Pharmacists of British Columbia

Professional Practice Policy #66

Policy Guide

Slow Release Oral Morphine (SROM) Maintenance Treatment (2018)

Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to SROM maintenance treatment must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC (CPBC) *Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily witness ingestion or daily dispense (i.e., 7 days per week) the pharmacy hours of service need to accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for SROM maintenance treatment from 'daily witness' to a 'take-home' dose.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take SROM.

Note: See Principle 4.1.4 for detailed administration requirements.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, craving, and/or non-medical opioid use.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*. Recommend completion of online training through the University of British Columbia Faculty of Medicine Continuing Professional Development's Provincial Opioid Addiction Treatment Support Program.

2.0 Receiving SROM Prescriptions

2.1 Controlled Prescription Program Forms – Overview

Principle 2.1.1 SROM prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting SROM prescriptions, the pharmacist must ensure that the Controlled Prescription Program Form is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) SROM Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 SROM for maintenance must be dispensed in approved, commercially available strengths and formulations. Capsule contents cannot be split.

Principle 3.1.2 **Guideline:** Only the once-daily, 24-hour formulation of SROM has been studied in clinical trials for the treatment of opioid use disorder. Other formulations of oral morphine, such as twice-daily, 12-hour sustained- or extended-release formulations, have not been empirically studied in this context and are not recommended. Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient, to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g., weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Pharmacists and pharmacy technicians must correctly identify the product as prescribed 'for pain' or 'Opioid Agonist Treatment (OAT)' by using the appropriate Drug Identification Number (DIN) or Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

Guideline: Effective June 5, 2017, PharmaCare established PINs for the use of Kadian® SROM as OAT. These PINs are to be used when submitting claims for the various dosing strengths through PharmaNet. Similar to methadone, DINs will be used by pharmacists exclusively for claims for analgesia, and the PINs will be used for claims for OAT.

Prescriptions for Kadian® should specify whether it is designated for analgesia or OAT (i.e., "for OAT" or "for opioid agonist treatment" is to be indicated on the prescription). If there is a question as to whether the prescription is for OAT (i.e., indicated by the dose strength, directions to

"open and sprinkle" capsules for daily witnessed ingestion, or other elements of the prescription), but the prescription lacks the explicit indication "for OAT", the pharmacist should contact the prescriber to confirm the intended use prior to dispensing the medication and properly document any alteration of the prescription.

The claim entered into PharmaNet should match the prescription written by the prescriber. If a claim marked "for OAT" has been entered under the DIN rather than under the PIN for Kadian® for OAT, it must be reversed, following the full standard procedure for reversing a claim entered under the wrong DIN or PIN. Only after a claim has been reversed can it then be re-entered with the correct PIN.

Principle 3.2.2 As with all medications a pharmacist must review each individual PharmaNet patient record, as stated in *HPA Bylaws* (Schedule F Part 1), and resolve any drug-related problems prior to dispensing any SROM prescription. This step is particularly critical for SROM for OAT prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system **does not include SROM for OAT**.

Pharmacists providing SROM for OAT maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to SROM.

Guideline: A PharmaNet patient record review should be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of SROM and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the SROM maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the SROM maintenance program.

Co-ingestion of SROM with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing SROM for OAT Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the SROM prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a SROM prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a SROM prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *SROM Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

Principle 4.1.4 With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

Guideline: SROM has a high risk of diversion, even when administered as witnessed doses (e.g., intact capsules can be 'cheeked' or 'palmed').

To reduce the risk of diversion, daily witnessed ingestion doses should be prepared by opening the capsule(s) and sprinkling the enclosed pellets for immediate ingestion. The patient should be instructed that pellets must not be chewed or crushed.

Pellets may be sprinkled into a 30 mL medicine cup or small cup followed by at least 30 mL of water to ensure that all pellets have been swallowed.

Immediately following observing the patient's ingestion of the medication, the pharmacist should ensure that the entire dose has been swallowed. This may include: engaging the patient in short conversation, asking the patient if there are pellets remaining in their teeth or gums, offering additional water for rinsing, or inspecting the inside of the patient's mouth.

Important Safety Notice: SROM pellets must be swallowed whole. Crushing, chewing, or dissolving slow-release oral morphine capsules or pellets can cause rapid release and absorption of a potentially fatal dose of morphine sulphate.

Principle 4.1.5 If take home doses (carries) are prescribed, the first dose must be a witnessed ingestion. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is

not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Note that the majority of prescriptions for SROM will be for daily witnessed ingestion (DWI). In exceptional cases, patients may be transitioned to take-home dosing schedules. If a patient's prescription indicates transition to a take-home dosing schedule for SROM, it is best practice to call and confirm with the prescriber.

Compliance packaging (e.g., blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy still needs to ensure that the medications are provided in child-resistant packaging.

Patients should be reminded that SROM should be stored out of the reach of children, preferably in a locked cupboard or small lock box.

5.0 Responding to SROM Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any SROM prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up SROM doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses before the next scheduled release of medication. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for this purpose.

Principle 5.1.4 If a patient misses 2 or more consecutive doses, the prescription must be cancelled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder* - Appendix 3: Induction and Dosing Guidelines for Slow Release Oral Morphine.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the documentation and communication.

The *SROM Part-Fill Accountability Log* (Appendix 1) can be used for the Part-Fill Accountability Log.

5.3 Vomited Doses

Principle 5.3.1 If a patient reports that they vomited their dose, a replacement dose cannot be provided. The pharmacist must notify the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Lost or Stolen Doses

Principle 5.4.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.5 Tapering

Principle 5.5.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

SROM Part-Fill Accountability Log

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their slow release oral morphine dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

Resolutions of the Board of the College of Pharmacists of British Columbia made in accordance with section 13(12) of the *Health Professions Act* – Bylaws.

1. Be it resolved that the Board amend the effective date of the previously approved amendments to *Professional Practice Policy 71* ("PPP-71") – *Delivery of Opioid Agonist Treatment*, as circulated, to be effective immediately upon approval of the Board.

2. Be it resolved that that Board amend the effective date of the previously approved consequential amendments to the following Professional Practice Policy ("PPP") and associated Policy Guides as circulated, to be effective immediately upon approval of the Board:

    a. *PPP-66 Opioid Agonist Treatment*
    b. PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment
    c. PPP-66 Policy Guide Methadone Maintenance Treatment
    d. PPP-66 Policy Guide Slow Release Oral Morphine Maintenance Treatment

_____ _____

Christine Antler, Chair, District 2 Date

_____ _____

Anca Cvaci, Vice-Chair, District 6 Date

_____ _____

Alex Dar Santos, District 1 Date

_____ _____

Andrea Silver, District 3 Date

Steven Hopp, District 4	Date
Michael Ortynsky, District 5	Date
Claire Ishoy, District 7	Date
Bal Dhillon, District 8	Date
Tracey Hagkull, Government Appointee	Date
Anne Peterson, Government Appointee	Date
Katie Skelton, Government Appointee	Date
Justin Thind, Government Appointee	Date