Decision Support Tool

For Registered Nurse/Registered Psychiatric Nurse Opioid Use Disorder Certified Prescribing of Buprenorphine

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About This Decision Support Tool

Intended Audience

Developed for registered nurses (RNs) and registered psychiatric nurses (RPNs) who:

- Have completed the Provincial Opioid Addiction Treatment Support Program (POATSP) Registered Nurse/Registered Psychiatric Nurse Opioid Use Disorder Certified (RN/RPN CP-OUD) Education and Training Pathway from the BC Centre on Substance Use (BCCSU), and
- Meet the competency requirements for buprenorphine/naloxone (bup/nlx) and extended-release buprenorphine prescribing, and
- Have RN/RPN CP-OUD designation with the BC College of Nurses and Midwives (BCCNM), and
- Have authorization from their employer to practice as an RN/RPN CP-OUD in their current role
- NOTE: Nurses and Nurse Practitioners of BC stewards the competencies for Certified Practices, including opioid use disorder (OUD) Certified Practice

Purpose

This decision support tool (DST) sets out the activities that are within the scope of RNs/RPNs CP-OUD who are prescribing bup/nlx and extended-release buprenorphine for individuals with OUD, as well as the situations in which consultation or referral is required. This document refers to the sublingual tablet formulation of bup/nlx.

Using This Document

- This document must be used alongside:
  - BCCNM scope of practice standards, limits, conditions for RNs CP-OUD and RPNs CP-OUD
  - BCCNM Opioid Use Disorder Prescribing - Consulting and Referring
  - *Guideline for the Clinical Management of Opioid Use Disorder (2023)*
- Opioid use disorder care should be approached in a manner that is evidence-informed, trauma- and violence- informed, culturally safe and humble, person-centred, and harm reduction-oriented

Definitions

- "Consult" is defined as seeking professional guidance or expertise for a particular concern from a physician (MD) or nurse practitioner (NP) and using this to inform your clinical decisions which you remain solely accountable for.
- "Refer" is defined as the process in which a RN/RPN CP-OUD hands a client over to an MD or NP as the client's disease, disorder, or condition is out of their scope of practice or beyond their individual competence.

Development

This DST was developed in alignment with the provincial *Guideline for the Clinical Management of Opioid Use Disorder (2023)* by a committee of experts, consisting of partners from the BCCNM, Ministry of Health, Ministry of Mental Health and Addictions, regional health authorities in BC, and relevant BCCSU staff. Consultation occurred with key stakeholders who supported the scope and definition of the work as well as ensuring the quality of the education and clinical support tools. Reviewers included partners from First Nations Health Authority, Island Health, Fraser Health, Vancouver Coastal Health, Northern Health, and Interior Health.

Scope of Practice: Bup/nlx and Extended-release Buprenorphine

RNs/RPNs CP-OUD who have completed the education and training for bup/nlx and extended-release buprenorphine prescribing are authorized to prescribe, administer, or dispense either medication as opioid agonist treatment (OAT). RNs/RPNs CP-OUD may also prescribe, administer, or dispense adjunct medications (e.g., clonidine) for managing withdrawal symptoms during a bup/nlx induction, as well as medications for managing opioid-induced constipation throughout the course of treatment with bup/nlx and extended-release buprenorphine. RNs/RPNs CP-OUD who have not completed the required training to prescribe methadone or slow-release oral morphine (SROM) must **refer** to an alternative OAT prescriber for all methadone or SROM prescriptions. If decision making is still unclear after reviewing this DST, please consult with an MD/NP or the 24/7 Addiction Medicine Clinician Support Line at 778-945-7619.

The Sublocade product monograph was updated by Health Canada in December 2025, to reflect the addition of on-label prescribing of alternative injection sites and a rapid induction. Please consult the Extended-release Buprenorphine Bulletin for updated information. While CP-OUD DST revisions are in progress to determine CP-OUD RN/RPN clinical decision-making points in relation to these updates, CP-OUD RNs/RPNs are required to consult with an MD/NP to determine a patient's clinical suitability for alternative injection sites and/or rapid induction.

When to Consult or Refer for Bup/nlx and Extended-release Buprenorphine

Doses	Co-occurring Central Nervous System (CNS) Depressant Use	Pregnancy or Chest-feeding	Severe Hepatic Dysfunction	Youth		Contraindications	Complex Acute or Chronic Illness
				15 years or younger	16–18 years of age		
Consult for bup/nlx: Doses above 32mg/8mg **Consult** for extended-release buprenorphine: 300mg/1.5mL maintenance dose	**Consult or refer** as outlined in Box 5 for prescribed or non-prescribed CNS depressant use (e.g., benzodiazepines, z-drugs, alcohol, and opioids) **Prescribed alternatives:** **Consult** if the client is on a prescribed alternative (e.g., hydromorphone, sufentanil, or fentanyl tablets or patch)	**Consult** for bup/nlx: In the absence of a treatment plan from an addiction medicine specialist **Refer** for extended-release buprenorphine: Clients who are or become pregnant during treatment	**Consult** if gamma glutamyl transferase (GGT) or alanine aminotransferase (ALT) is greater than 3 times the upper limit of the normal range, or albumin (34–50g/L) or total bilirubin (<17µmol/L) is outside of the normal range See Box 7	**Refer**	**Consult**	**Consult** or **refer** if contraindication present, as outlined in Appendix 1	**Consult** or **refer** if known complex acute or chronic illness, as outlined in Box 1

Prescriber Collaboration

Initiations, Continuations, Titrations, and Restarts

In certain situations, outlined in this DST (e.g., client is co-prescribed a CNS depressant), RNs/RPNs CP-OUD are required to consult for initiations, continuations, titrations, and restarts. When an initial consultation with an MD/NP is necessary for a given client's continuation, RNs/RPNs CP-OUD are not required to consult again for continuation if the client's medications and clinical stability remain unchanged.

Opioid Use Disorder

Diagnosis

Before RNs/RPNs CP-OUD prescribe OAT, they should diagnose the client using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Diagnostic Criteria for Opioid Use Disorder and assess the severity of OUD.

RNs/RPNs CP-OUD are not trained or authorized to manage chronic pain and cannot prescribe opioids for this purpose. Clients who do not meet the criteria for OUD and are seeking care for chronic pain should be referred to an MD/NP. RNs/RPNs CP-OUD may prescribe OAT for individuals with OUD who may have chronic pain. However, a referral to an MD/NP will be necessary for chronic pain management. If the existence of chronic pain makes the diagnosis of OUD unclear, consult with an MD/NP or the 24/7 Addiction Medicine Clinician Support Line at 778-945-7619.

Selecting Opioid Agonist Treatment Medication

A variety of factors are relevant in selecting an OAT medication. RNs/RPNs CP-OUD should work with each client to determine which medication is best suited, based on their circumstances, goals, and previous treatment experiences.

The table below outlines details regarding the initiation, safety, side effects, dosing, rotation, and tapering of bup/nlx, extended-release buprenorphine, methadone, and SROM.

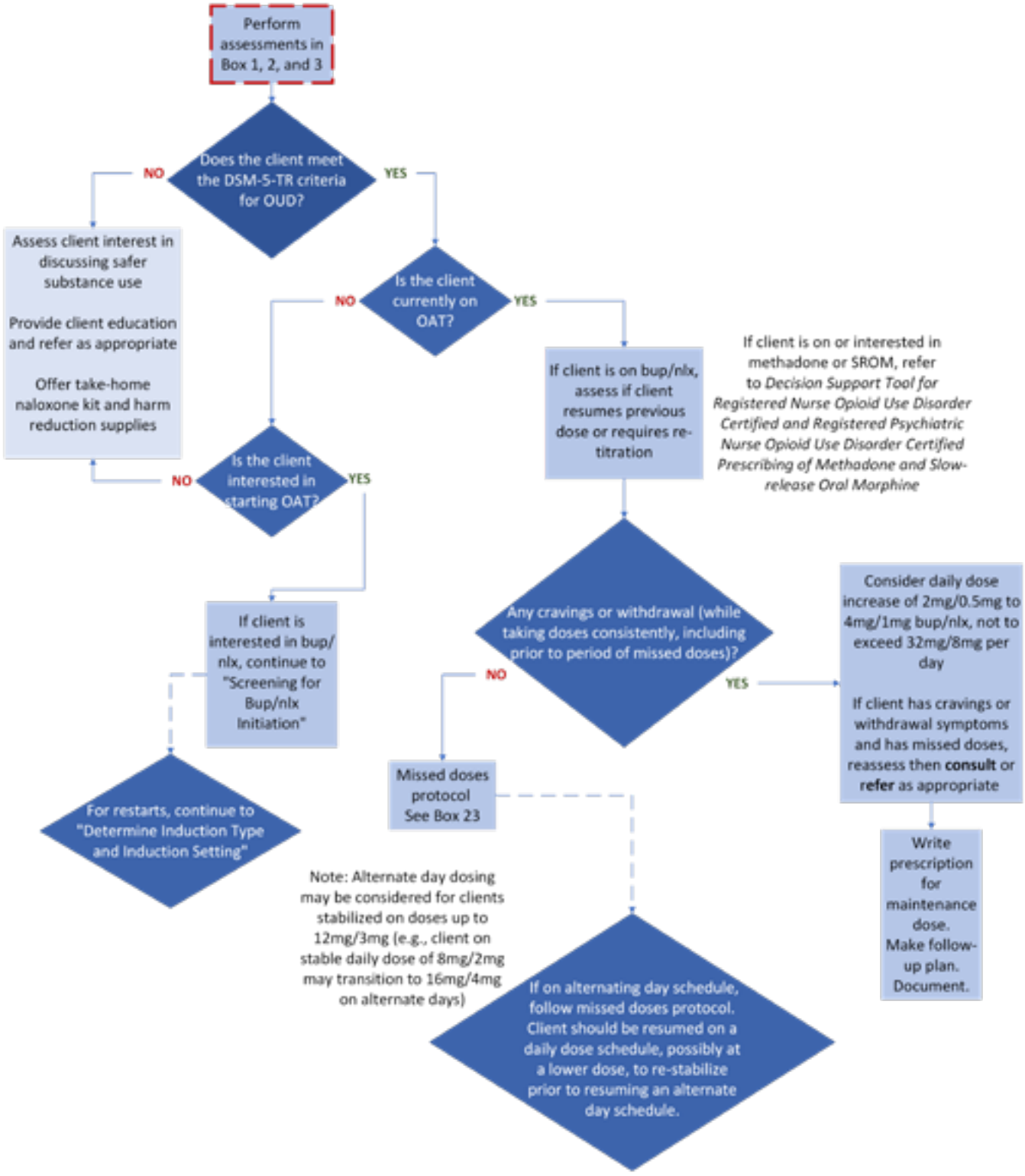
	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo	Potentially slightly better treatment retention than bup/nlx	Non-inferior to methadone
Initiation				
Requires withdrawal prior to induction	**Traditional induction:** Yes. Requires moderate withdrawal prior to induction **Low-dose induction:** No. Does not require prior withdrawal, allowing for comfortable start	No. Does not require a period of withdrawal, but requires prior stabilization on bup/nlx	No. Does not require a period of withdrawal. May be easier to initiate	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration
Time to achieve therapeutic dose	**Traditional induction:** (1–3 days) Shorter time to achieve therapeutic dose **Low-dose induction**: (5–10 days) Takes longer to reach therapeutic dose	2 months on 300mg/1.5mL injections, followed by 100mg/0.5mL maintenance dose every 4 weeks	Longer time to achieve therapeutic dose (may take weeks)	1–2 weeks
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on bup/nlx prior to initiation	N/A	N/A
Safety				
Risk of drug poisoning	Low. Due to ceiling effect for respiratory depression in the absence of co-occurring use of CNS depressants	Low. Due to ceiling effect for respiratory depression in the absence of co-occurring use of CNS depressants	Higher. Particularly during treatment initiation	Comparable safety profile to methadone, though less well-described
Drug–drug interactions	Few	Few	Higher potential for adverse drug–drug interactions (e.g., antibiotics, antidepressants, antiretrovirals)	Fewer than methadone
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Risk of precipitated withdrawal during initiation	Yes	No, due to need for stabilization on bup/nlx first	No	No

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
Side effects				
Side effects	Milder side effect profile	Medication adverse effects are similar to bup/nlx Injection site pain and pruritus	More severe dose-dependent side effect profile (e.g., sedation, weight gain, erectile dysfunction, cognitive blunting)	Comparable to methadone, though less well-described Possibly fewer subjective side effects
Dosing				
Dosing	Health Canada-approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some clients Alternate day dosing possible May be suboptimal for individuals with very high opioid tolerance	First 2 months: Monthly dose of 300mg/1.5mL Maintenance dose: Monthly dose of 100mg/0.5mL (though some clients may benefit from remaining at a 300mg/1.5mL maintenance dose)	No maximum dose specified in the product monograph	No maximum dose specified in the product monograph
Take-home doses	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased client autonomy and cost savings Advantageous for rural and remote locations	N/A	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with daily witnessed ingestion (DWI) • Clinical and psychosocial stability	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability
Rotation				
Rotation	Easier to rotate from bup/nlx to methadone or SROM	Rotation to other OAT medications is challenging. Avoid transitioning to a full agonist, if possible Consult with the 24/7 Addiction Medicine Clinician Support Line if needed	Risk of precipitated withdrawal when rotating to bup/nlx May be rotated directly to SROM	Risk of precipitated withdrawal when rotating to bup/nlx May be rotated directly to methadone
Tapering off				
Tapering off	Milder withdrawal symptoms; easier to discontinue May be a better option for individuals with lower-intensity physical opioid dependence	Milder withdrawal symptoms Buprenorphine concentrations are decreased slowly over time following the last injection and may take months for buprenorphine to leave the system completely	More severe withdrawal symptoms	Comparable to methadone

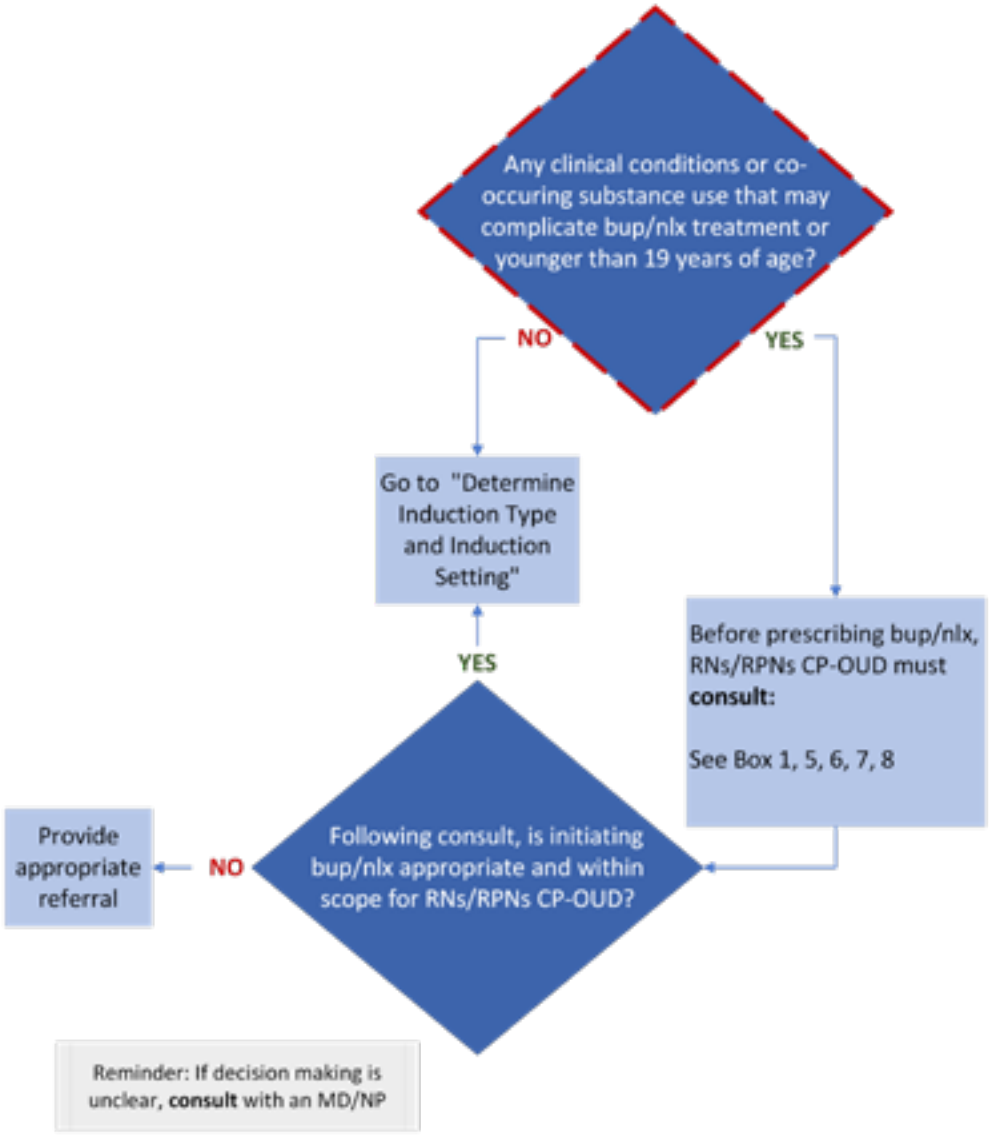
Decision Support Tool

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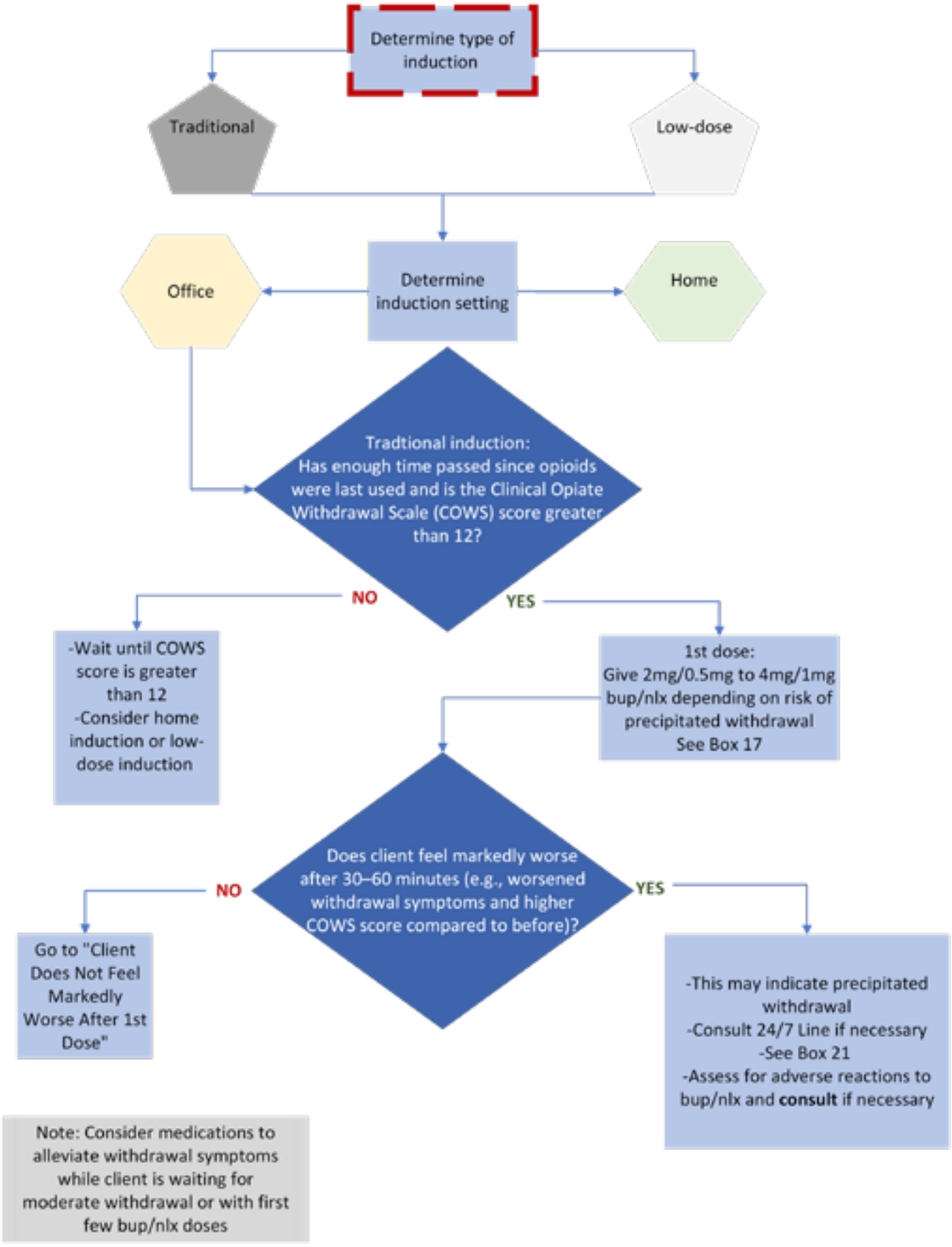
Bup/nlx: Screening for Prescribing



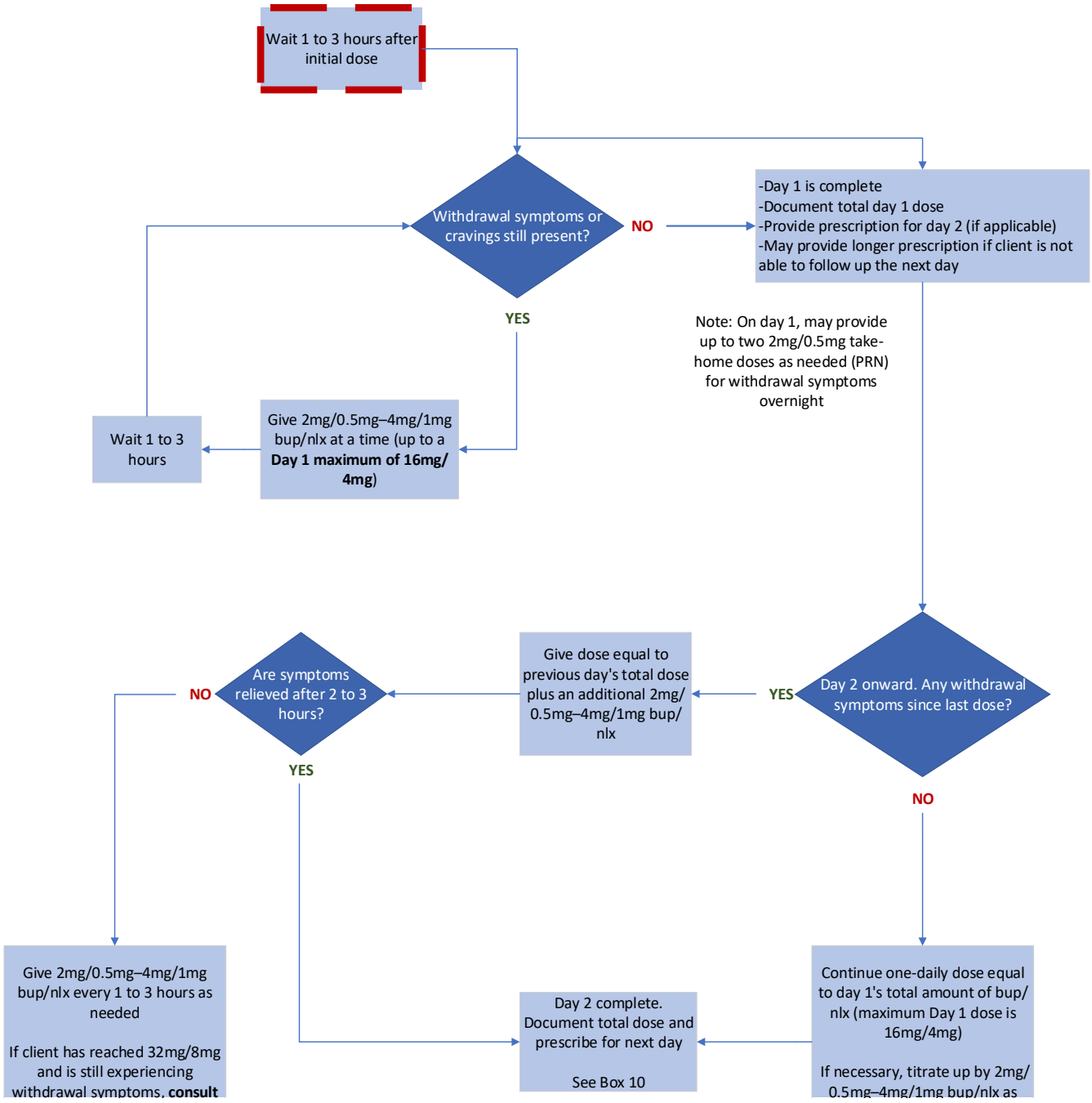
Bup/nlx: Screening for Initiation



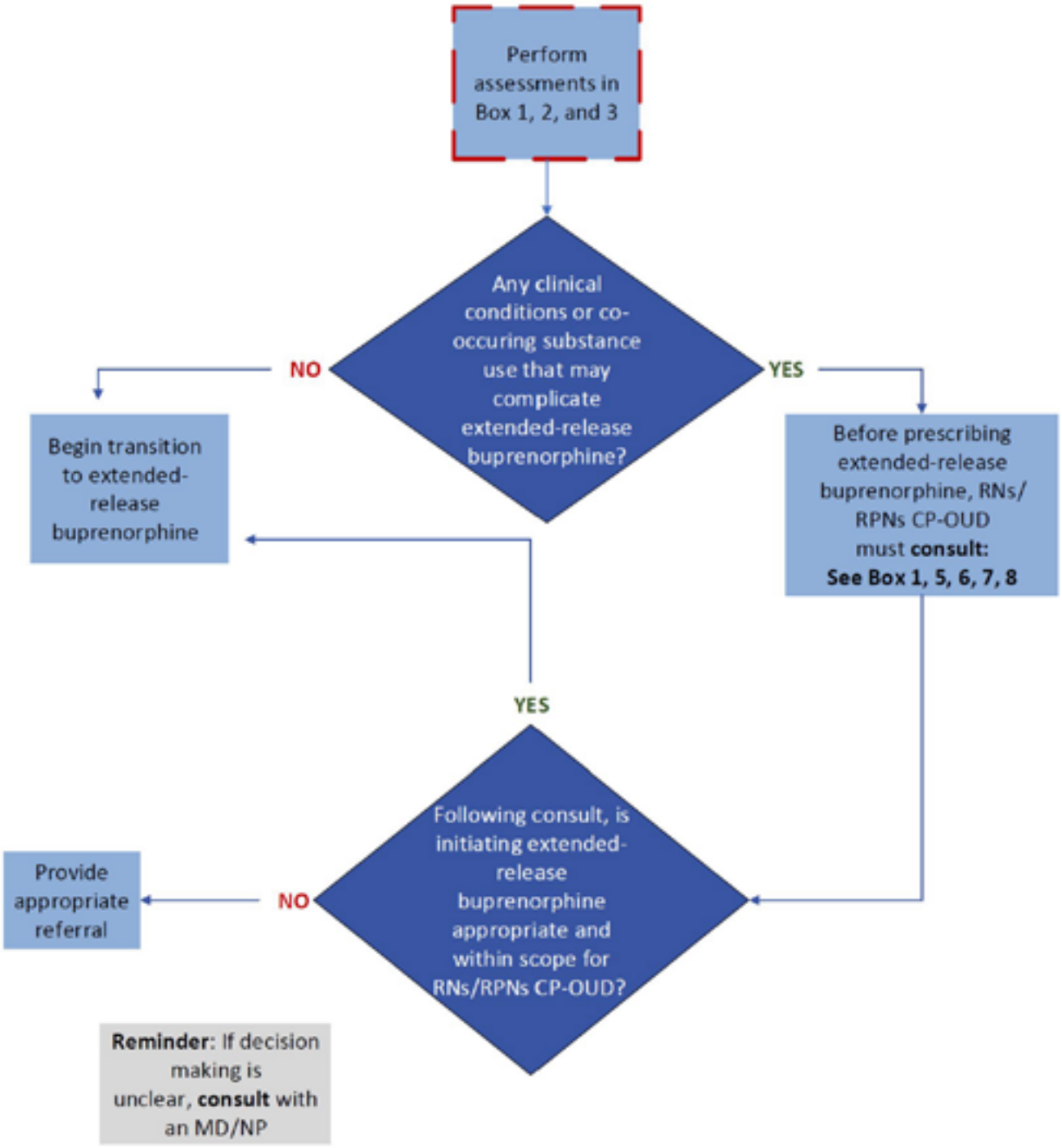
Bup/nlx: Determine Induction Type and Induction Setting



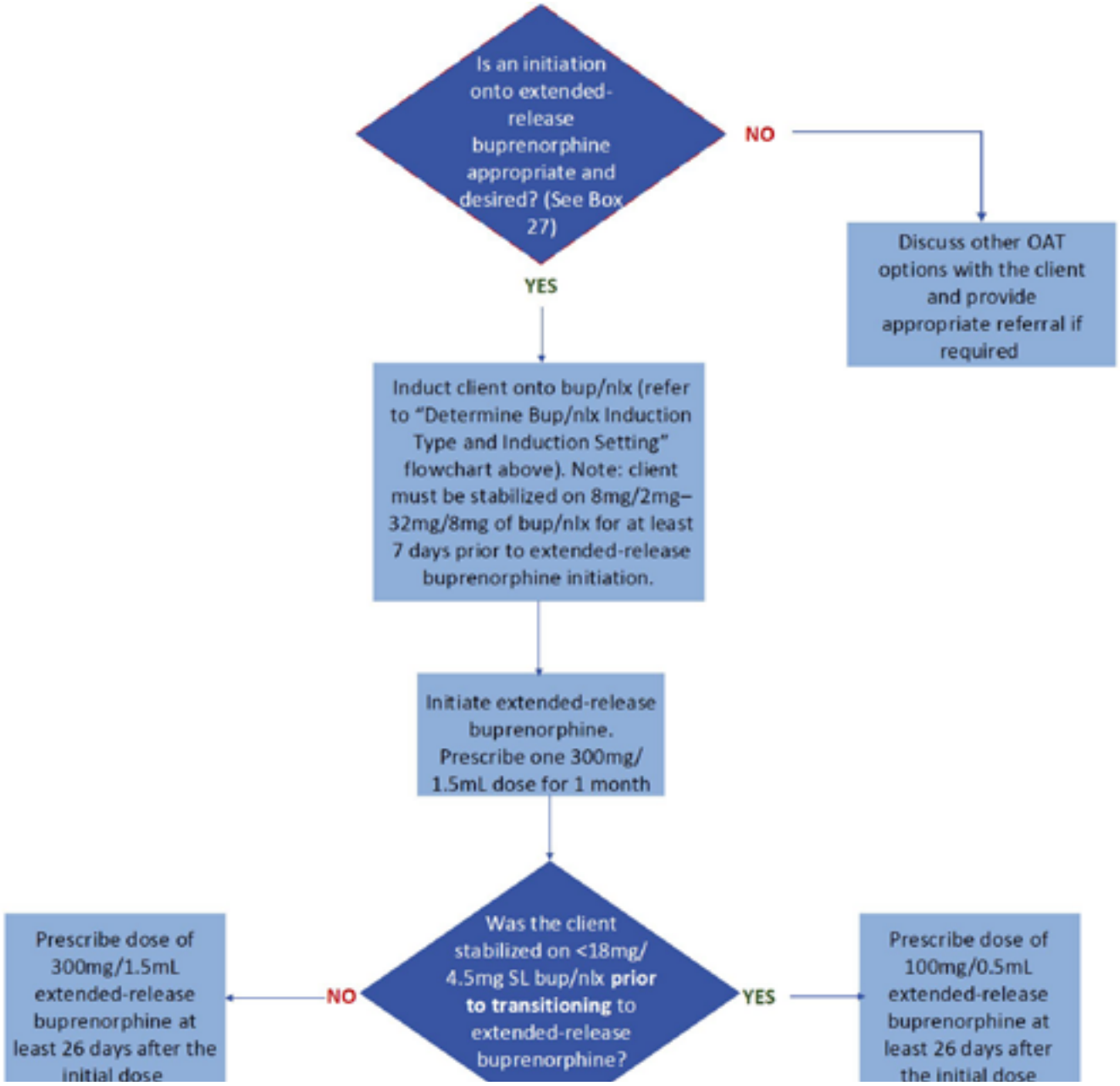
Bup/nlx: Client Does Not Feel Markedly Worse After 1st Dose



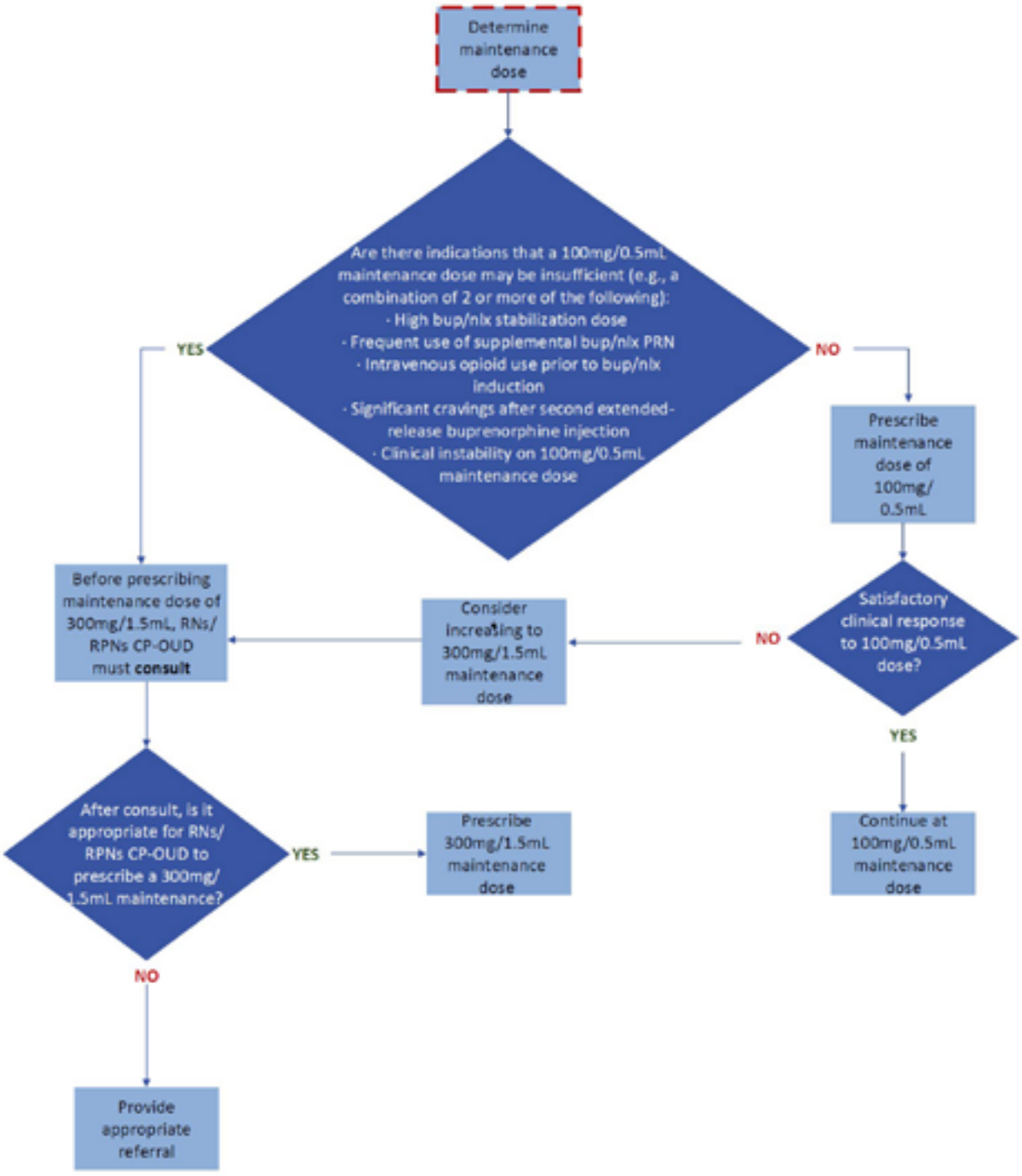
Screening for Extended-release Buprenorphine Prescribing



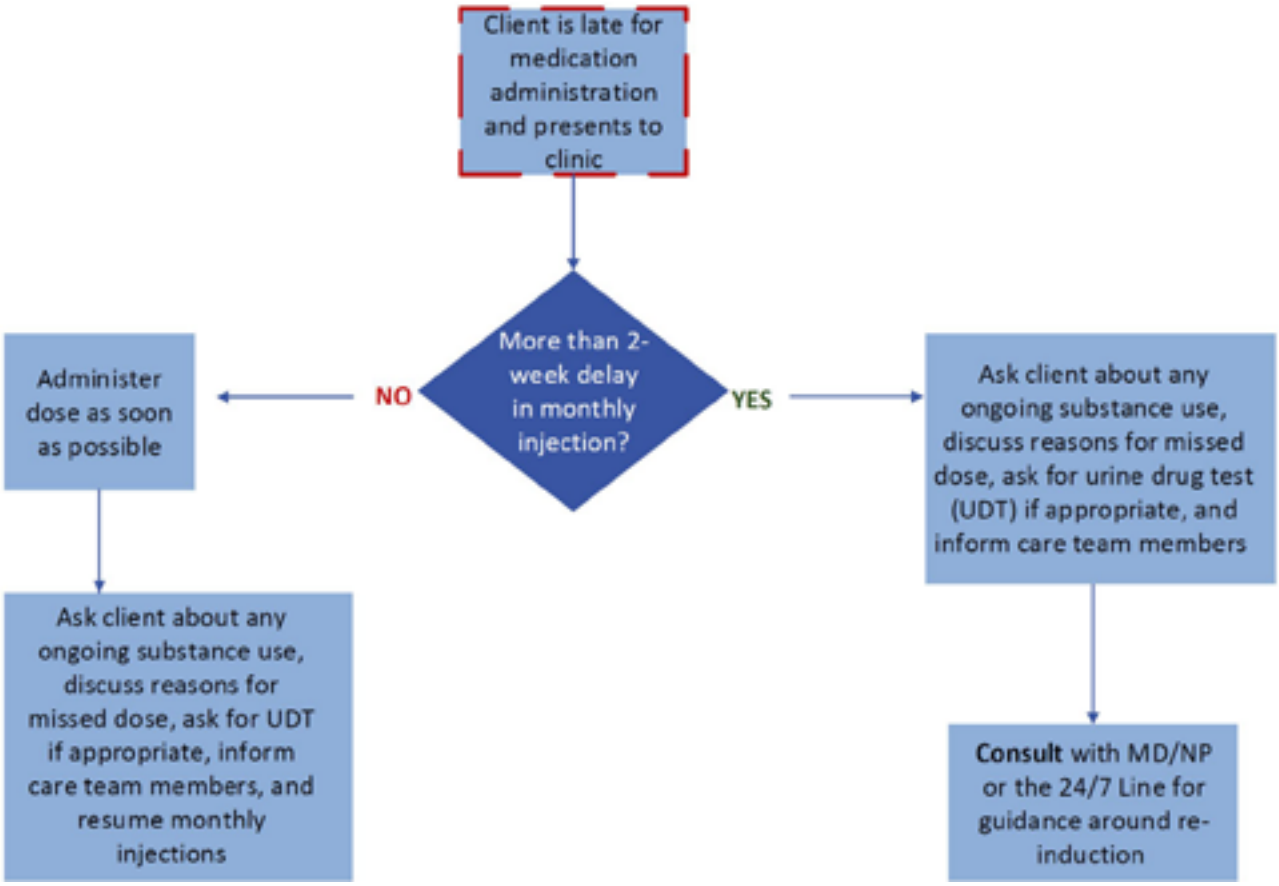
Extended-release Buprenorphine Initiation



Determining Maintenance Dose of Extended-release Buprenorphine



Missed Dose of Extended-release Buprenorphine



Need to Know

This section provides more detailed information on RNs/RPNs CP-OUD prescribing of bup/nlx and extended-release buprenorphine for initiations, continuations, titrations, and restarts—informed by *A Guideline for the Clinical Management of Opioid Use Disorder (2023)* and product monographs. Additional information regarding when to seek consultation or referral is listed below. Information specific to bup/nlx and extended-release can be found on page 31 and 41, respectively.

If the client is experiencing clinical instability at any point during your assessment (e.g., unstable vital signs, decreased level of consciousness), they should be referred to an appropriate level of care (e.g., referral to the emergency department in the case of suspected increased intracranial pressure, acute appendicitis, or any presentations that require immediate assessment). Individuals may also need an assessment by an MD/NP for primary care follow-up, which should be facilitated by the RN/RPN CP-OUD.

In the context of extended-release buprenorphine, RNs/RPNs CP-OUD should be aware of the client's previous clinical assessments and medication administration. Complete consultations and referrals in a timely manner to ensure the client receives their next dose on schedule. Communication with other care providers regarding the client's dosage requirements is essential to ensure treatment needs are met.

Box 1. Complex Acute or Chronic Illness Assessment Findings and Interventions

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
CNS depressant use: • Acute alcohol intoxication • Alcohol withdrawal • Benzodiazepine withdrawal	• History or assessment suggestive of alcohol intoxication (e.g., slurred speech, unsteady gait, lack of coordination, reported alcohol use) • History or assessment suggestive of alcohol withdrawal (e.g., irritability, tremors, anxiety, diaphoresis) or alcohol use disorder (AUD) • History or assessment suggestive of benzodiazepine withdrawal (e.g., headache, nausea, paranoia, seizures) or sedative use disorder	If the client is acutely intoxicated, wait until they are no longer intoxicated and screen for withdrawal symptoms and AUD or sedative use disorder **Consult** for initiations, continuations, titrations, and restarts if the client has new alcohol use that exceeds 4 drinks (adult women) or 5 drinks (adult men) on any single occasion or other new CNS depressant use **Refer** if the client is experiencing alcohol or benzodiazepine withdrawal symptoms **Refer** for initiations if the client has AUD or sedative use disorder **Consult** for continuations, titrations, and restarts if the client displays signs of clinical instability, CNS depressant use has changed significantly, or has newly diagnosed or worsening AUD or sedative use disorder
Cardiac conditions such as: • Arrhythmia • Unstable angina • Post-myocardial infarction • Congestive heart failure • Congenital Long QT Syndrome or QT prolongation at baseline	• Previous diagnosis by MD/NP • Electrocardiogram (ECG) or Holter monitoring confirmation • Echocardiogram (ECHO) • Physical assessment (e.g., irregular heartbeat, dizziness, syncope, crackles or rales, increased edema, or weight gain)	**Consult** for initiations, titrations, or restarts if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or there is a change in the client's presentation

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
Thrombophilia/clotting disorders **(specific to extended-release buprenorphine)**	• Previous diagnosis by MD/NP • Current prescription for anticoagulants • Abnormal prothrombin time/international normalized ratio (INR) test results o INR normal range: 0.8–1.1	**Consult** for previous diagnosis, prothrombin time/INR test results outside of normal ranges, or current prescription for anticoagulants

Gastrointestinal (GI) conditions such as:
• Paralytic ileus (known or suspected)
• Bowel obstruction
• Suspected surgical abdomen (e.g., acute appendicitis or pancreatitis)
• Acute diarrheal illness*
• Distended abdomens **(specific to extended-release buprenorphine)**
  o E.g., ascites
	• Previous diagnosis by MD/NP
	• Confirmed imaging
	• Physical assessment (e.g., abdominal bloating and distension)
	  o For extended-release buprenorphine: Ensure injection can be properly and comfortably administered
	• Bloodwork and/or cultures
		Consult for initiations with acute diarrheal illness if the client is clinically stable
		Refer to an appropriate level of care for all other GI conditions
		*If the client is experiencing acute diarrheal illness, assess for opioid withdrawal

Skin conditions **(specific to extended-release buprenorphine)**	• Previous diagnosis by MD/NP • Physical assessment (e.g., nodules, lesions, excessive pigment)	**Consult** for skin conditions that may impact the ability to properly administer the medication
Severe respiratory conditions such as: • Acute asthma • Pneumonia • Chronic obstructive pulmonary disorder (COPD) exacerbation	• Previous diagnosis by MD/NP • Diagnostic pulmonary function tests • History of hospitalization for COPD • Rapid respiratory rate (>20 breaths per minute) • Decreased oxygen saturation (<92% SpO2) • Increased work of breathing (e.g., tripod, unable to speak in full sentences) • Decreased air entry • Wheezing upon auscultation	**Consult** for initiations if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or there is a change in the client's presentation

Complex Acute or Chronic Illness or Presentation	As Evidenced by:	Action
Severe hepatic conditions such as: • Cirrhosis • Hepatocellular carcinoma • Acute hepatitis • Liver failure	• Previous diagnosis by MD/NP • Evidence on computed tomography (CT) scan, FibroScan, or ultrasound • Abnormal liver enzymes: If GGT or ALT are over 3 times the upper limit of normal, or albumin or total bilirubin are outside of the normal ranges o Albumin normal range: 34–50g/L o Total bilirubin normal range: <17µmol/L	**Consult** for initiations if the client is clinically stable **Consult** for restarts if the client is clinically stable **Refer** for acute hepatitis, liver failure, signs of clinical instability, or if there is a change in the client's presentation
Sepsis	• Previous diagnosis by MD/NP • Physical assessment (e.g., febrile, dizziness, change in mental state) • Abnormal bloodwork (e.g., elevated white blood cell count) • Abnormal imaging suggesting infection	**Refer** to an appropriate level of care if the client displays signs of clinical instability
Severe CNS conditions such as: • Brain tumor • Recent head injury • Increased cerebrospinal or intracranial pressure	• Previous diagnosis by MD/NP • Neurological and physical assessment (e.g., new onset of severe headache, blurred vision, acute confusion and memory loss, nausea and vomiting, difficulties with walking or speaking) • Unstable vital signs • Abnormal imaging or tests (e.g., X-ray, CT scan, magnetic resonance imaging [MRI], lumbar puncture)	**Consult** for initiations if the client is clinically stable **Refer** to an appropriate level of care if the client displays signs of clinical instability or if there is an acute change in the client's presentation
Seizure disorder or epilepsy	• Previous diagnosis by MD/NP • Seizure disorder confirmed by electroencephalogram (EEG) • History of seizures • Anti-convulsant medication for the treatment of seizures	**Consult** for initiation if the client is clinically stable **Refer** if the client displays signs of clinical instability or there is a change in the client's presentation
For extended-release buprenorphine: If a consultation or referral has recently been completed for a client presenting with a complex acute or chronic illness (e.g., prior to bup/nlx stabilization), further consultation or referral is not necessary unless there are signs of clinical instability or a change in the client's presentation. Note: this does not apply to individuals who present with severe hepatic dysfunction (see Box 7) Upon review of bloodwork, if there is any history of abnormal values outside of the values listed in this table, consider consulting with an MD/NP as appropriate		

Box 2. Client Eligibility

Overall eligibility criteria:

1. Presence of OUD
2. Informed consent
3. No contraindications for the medication, severe chronic or acute disease, allergy or hypersensitivity to the medication or any component of the formulation, severe respiratory insufficiency, delirium tremens, or acute alcohol intoxication

Buprenorphine/naloxone eligibility:

1. Ensure adequate time has passed since the last opioid use to prevent precipitated withdrawal (for traditional inductions)

Extended-release buprenorphine eligibility:

1. According to the product monograph, extended-release buprenorphine is indicated for adults who have been inducted and stabilized on at least 8mg/2mg–24mg/6mg/day of bup/nlx for a minimum of 7 days. However:
    - Clients stabilized on 24mg/6mg–32mg/8mg of bup/nlx may be eligible (see Box 27)
    - Clients stabilized on bup/nlx for fewer than 7 days may be eligible (see Box 28)
    - Clients who are 18 years of age or younger may be eligible (see Box 8)

Box 3. Client Assessment Before Prescribing

1. Obtain informed consent to perform an assessment
2. **Reminder:** RNs/RPNs CP-OUD must assess the client in-person or through virtual care with a visual assessment
   - If a visual assessment is not possible, RNs/RPNs CP-OUD can only prescribe to known clients or clients that have been assessed in person by another health care provider
3. Conduct a Best Possible Medication History (BPMH) and PharmaNet review
   - Determine any OAT medication prescribed and when it was last prescribed (if applicable)
   - If applicable, contact the care provider from the most recent OAT prescription to ensure collaboration and appropriate communication
     - This should not delay the OAT prescription
     - The client's regular prescriber may want to follow up with the client at a later date
     - Consider an encounter note to maintain open communication pathways
   - Review for current prescription of prescribed alternatives
     - **Consult** if the client has a prescription for prescribed alternatives by another provider
   - Determine whether any new medications have been prescribed since the last OAT prescription
     - **Consult** or **refer** as appropriate if medication or allergy contraindications or drug–drug interactions are identified during the BPMH and PharmaNet review (see Appendix 1 and UpToDate)
4. Review substance use and past medical history with the client
5. Conduct physical assessment as needed
   - When prescribing extended-release buprenorphine, it is crucial to thoroughly assess and discuss any pertinent skin conditions, clotting disorders, or other considerations relevant to prescribing with the client
6. Assess the client's goals
   - Include treatment goals (e.g., immediate take-home doses), current housing, income, social support, cultural and wellness supports, identified strengths, and legal support
   - Connect with the health care team and refer as appropriate
7. Offer lab tests as appropriate (see Appendix 2)
   - Note that the continuation of OAT should not be delayed while waiting for bloodwork
   - Urine drug test, when clinically indicated (see Appendix 2)
   - Pregnancy test, when appropriate
8. Assess for new complications, such as adverse reactions
9. Review medication coverage

Box 4. Harm Reduction Education

Harm Reduction

1. Education on safer use practices to help prevent drug poisoning
   - Avoid using alone
   - Use a local supervised consumption site or drug poisoning prevention site
   - Use the Brave app or Lifeguard app
   - Use a small amount of drugs to start (i.e., a “test dose”)
   - Use drug checking services, if available
   - Risks of co-occurring substance use, including CNS depressant use or stimulants
2. Take-home naloxone
   - If a kit cannot be provided at the time, provide information on where to acquire one
   - Offer education and training on take-home naloxone for any relevant supports (e.g., family, friends, support staff)
3. Harm reduction supplies
   - Offer safer use supplies and the related education to support infection prevention (e.g., bacterial, HIV, HBV/HCV)
4. Information on available community resources as required or requested

Box 5. Co-occurring CNS Depressants

If the client is taking CNS depressants (prescribed or non-prescribed), such as benzodiazepines, z-drugs, opioids, or alcohol:

1. **Consult** for initiations, continuations, titrations, and restarts for clients with new alcohol use that exceeds 4 drinks (adult women) or 5 drinks (adult men) on any occasion in the past year, or other new CNS depressant use
2. **Consult** for continuations, titrations, and restarts if:
    - The client is clinically unstable, as demonstrated by increased sedation or increased risk of drug poisoning, or
    - Central nervous system depressant use has changed significantly in terms of substance, frequency, or dose, or if the client has newly diagnosed or worsening AUD or sedative use disorder
3. **Refer** for initiations if the client has a sedative use disorder or AUD
4. **Refer** if the client displays alcohol withdrawal symptoms or there is evidence of benzodiazepine withdrawal
    - Symptoms of benzodiazepine withdrawal include:
        - Anxiety, headache, vomiting, nausea, tinnitus, anorexia, tremor, weakness, irritability, tachycardia, seizures, paranoia, hallucinations, withdrawal delirium
        - The overlapping symptoms of benzodiazepine and opioid withdrawal can make it challenging to assess the severity of withdrawal from each substance and to distinguish between opioid and benzodiazepine withdrawal
    - Benzodiazepine withdrawal may be indicated by any of the following:
        - Benzodiazepine-positive UDT results **AND**
            - Due to the contaminated unregulated opioid supply, benzodiazepine-positive UDT results are common. Clients may be unaware they have consumed benzodiazepines. Referral is important when benzodiazepine withdrawal is a risk
        - Client displays 1 or more signs of benzodiazepine withdrawal **AND**
        - Client report of benzodiazepine use **OR**
        - Recent history of seizures during periods of abstinence **OR**
        - Moderate to severe withdrawal symptoms persist following OAT initiation

Box 6. Considerations for Bup/nlx and Extended-release Buprenorphine Prescribing in Pregnancy

1. All clients of childbearing capacity who are sexually active and are considering starting or restarting bup/nlx or extended-release buprenorphine, should be offered a pregnancy test
   - Note: A pregnancy test is not required to prescribe bup/nlx. A pregnancy test is strongly suggested prior to starting extended-release buprenorphine, as there is uncertainty regarding the safety of the Atrigel component in pregnancy
2. RNs/RPNs CP-OUD may consult the 24/7 Line at any point for questions about pregnant clients and OAT and substance use care
3. Further guidance can be found in the *Guideline for the Clinical Management of Opioid Use Disorder (2023)* and *Treatment of Opioid Use Disorder Pregnancy–Guideline Supplement*

Buprenorphine/naloxone

1. RNs/RPNs CP-OUD can continue bup/nlx prescriptions for clients who are pregnant but should ensure clients are being followed for perinatal and primary care
   - Where possible, these may be arranged through organizational consultations
2. **Consult** a perinatal addiction medicine specialist through the Rapid Access to Consultative Expertise (RACE) for Addiction App or through the organizational pathway in the absence of a treatment plan from an addiction medicine specialist

Extended-release Buprenorphine

1. RNs/RPNs CP-OUD must **refer** clients to an MD/NP for initiations, continuations, titrations, and re-starts for clients who are or become pregnant during treatment
2. Due to concerns about Atrigel's teratogenic potential, refer pregnant clients to a maternal-fetal or addiction medicine specialist for further consultation

Box 7. Considerations for Clients with Poor Hepatic Function

1. RNs/RPNs CP-OUD should screen clients for hepatic disease and order laboratory tests related to liver health (e.g., albumin, bilirubin, ALT, GGT) at the initiation of treatment and repeat 4 weeks after initiation
    - These tests are not required to initiate bup/nlx or extended-release buprenorphine
    - Abnormal liver function tests that are less than 3 times the upper limit of normal should not delay the prescription, but it is not within the RN/RPN CP-OUD scope of practice to interpret or manage elevated liver enzymes. These results will need to be assessed by an MD/NP. Connection to an MD/NP to follow up on these results can be made via organizational processes.

Buprenorphine/naloxone

1. If the client has severe hepatic dysfunction (e.g., elevated bilirubin levels) and is not currently taking or has never previously taken bup/nlx, RNs/RPNs CP-OUD must **consult** with an MD/NP using the 24/7 Line or organizational pathway before initiating a bup/nlx prescription and document this consultation
2. If the client has severe hepatic dysfunction and is currently on or has previously taken bup/nlx, RNs/RPNs CP-OUD must **consult** with an MD/NP before restarting bup/nlx for the client, either by using the 24/7 Line or organizational pathway
3. If the client has acute hepatitis, liver failure, signs of clinical instability, or if there is a change in the client's presentation, RNs/RPNs CP-OUD must **refer** to an MD/NP, either by using the 24/7 Line or organizational pathway

Extended-release Buprenorphine

1. If the client has severe hepatic dysfunction and is not currently taking or has never taken extended-release buprenorphine, RNs/RPNs CP-OUD must **consult** with an MD/NP, either by using the 24/7 Line or organizational pathway, before transitioning from bup/nlx to extended-release buprenorphine
    - RNs/RPNs CP-OUD must consult if the client has severe hepatic dysfunction, even if the client has been stable on bup/nlx
2. If the client has severe hepatic dysfunction and is currently on or has previously taken extended-release buprenorphine, RNs/RPNs CP-OUD must **consult** with an MD/NP, either by using the 24/7 Line or organizational pathway, before restarting extended-release buprenorphine for the client
3. If the client has severe hepatic dysfunction and they are clinically stable, RNs/RPNs CP-OUD may continue administering extended-release buprenorphine as long as there is no change in the client's clinical status or condition
4. If the client has acute hepatitis, liver failure, signs of clinical instability, or if there is a change in the client's presentation, RNs/RPNs CP-OUD must **refer**

Box 8. Considerations for Bup/nlx and Extended-release Buprenorphine Prescribing for Youth

1. In caring for youth, RNs/RPNs CP-OUD must have competence not only related to prescribing medications for the client but other considerations such as obtaining consent and related legislation, such as the *Infants Act*

Buprenorphine/naloxone

1. When prescribing, the *Treatment of Opioid Use Disorder for Youth–Guideline Supplement* and *A Guideline for the Clinical Management of Opioid Use Disorder (2023)* should guide care
   - Youth aged 16–18 years: **consult**
   - Youth aged 15 years or younger:
     - **Refer** to another provider
     - Provide other interventions within scope such as safety planning, provision of harm reduction supplies and education, relationship building, connection to health care services, and provision of a safe space to discuss the client's wellbeing

Extended-release Buprenorphine

1. According to the product monograph, extended-release buprenorphine is not indicated in individuals under 18 years old
2. When prescribing, *A Guideline for the Clinical Management of Opioid Use Disorder (2023)* should guide care
   - Youth aged 16–18 years: **consult**
   - Youth aged 15 years or younger:
     - **Refer** to another provider
     - Provide other interventions within scope such as safety planning, provision of harm reduction supplies and education, relationship building, connection to health care services, and provision of a safe space to discuss the client's wellbeing
   - Rapid inductions for youth 18 years or younger: **refer** to an MD or NP

Box 9. Alleviating Opioid-induced Constipation

1. Constipation is a common side effect caused by opioid use due to opioid-induced reduction in gut motility. The following information about constipation related to opioid use should be discussed with all clients:
   - Discuss the likelihood of constipation as a side effect of opioid agonist treatment
   - Advise clients on dietary modifications, including increasing fiber intake and ensuring adequate hydration
   - Encourage regular physical activity
2. Senna (sennosides) can be ordered, administered, and dispensed by RNs/RPNs CP-OUD to effectively manage constipation symptoms during the course of treatment with bup/nlx and extended-release buprenorphine
3. RNs/RPNs CP-OUD must **refer** the client to an MD/NP if constipation persists despite treatment, if there are signs of complications (e.g., bowel obstruction), or any symptoms that warrant further investigation (e.g., blood in the stool)

Table 1. Managing Opioid-induced Constipation

Initial Assessment	Dosage	Monitoring
• Evaluate client for symptoms of constipation associated with opioid use, including infrequent bowel movements, hard stools, dehydrated stools, or difficulty passing stools during initial and follow-up visits o Consider the duration of opioid treatment and client-reported bowel habits • Consider client history, current medication use, and other underlying health conditions that may contribute to constipation • Assess for any signs or symptoms that could warrant further investigation, such as blood in the stool	• 8.6–17.2mg PO once daily • Maximum dose 34.4mg/day • Adjust dose based on client response • Advise the client to take the medication in the evening to produce a bowel movement the next morning	• Evaluate the effectiveness and adjust dosage as necessary during follow-up visits • Document the following during all visits: Initiation date of senna, dosage adjustments, and client response • Monitor for signs of electrolyte imbalances and dehydration • Adjust the treatment plan accordingly if the client experiences adverse reactions to senna

Box 10. Stabilization and Follow Up

1. Once the client is stabilized on the medication, follow-up visits should be conducted at regular intervals of time depending on the medication (see below for more information), with the option to decrease follow-up visits as increased stability is achieved
2. Follow-up assessments should include:
   - Adequacy of dosage (e.g., client report of withdrawal symptoms or cravings)
   - Adverse effects
   - Review of drug–drug interactions (See Appendix 1 and UpToDate)
   - Substance use (via client report, and when clinically indicated, UDT)
   - Client goals and support for these goals
   - Physical and mental health
   - Psychosocial domains, as clinically indicated
     - Including housing, relationships, and finances
   - Education about harm reduction and safer consumption practices, as clinically indicated
   - Offering referrals to appropriate services
   - Health promotion
3. Urine drug tests should be done per clinician's discretion when the results may impact the treatment plan and clinical management of the client
4. Evidence of other non-medical opioid use or other substance use should prompt a reassessment of the treatment plan, but not automatic discontinuation of take-home bup/nlx doses
5. Non-medical opioid use or other substance use to address withdrawal and cravings may indicate that a higher dose is needed
6. Evidence of diversion (e.g., UDT negative for buprenorphine without missed doses in PharmaNet) should prompt re-engagement with the client to re-assess treatment plan

Buprenorphine/naloxone

1. Follow-up assessments should be conducted every 1–2 weeks with the option to decrease follow-up visits as increased stability is achieved
2. For clients prescribed take-home bup/nlx who show signs of major instability, individual client circumstances should be considered
   - Appropriate responses may include:
     - Increasing the frequency of clinical appointments in order to provide more intensive support, monitoring, and assessment
     - Reassessing dose, especially if the client is reporting cravings or withdrawal
     - Providing referrals to adjunct psychosocial and community-based supports as appropriate
3. If doses have been missed, follow missed doses protocol (see Box 23)

Extended-release Buprenorphine

1. Follow-up assessments should be conducted at least every month with the option to decrease follow-up visits as increased stability is achieved. Some clients may receive their extended-release buprenorphine injections from the pharmacist, who will be doing assessments (e.g., for indications of infection, cravings). The pharmacist and prescriber should be in regular contact about the client's progress.
2. Follow-up assessments should involve examining the injection site for any indications of infection and assessing breakthrough cravings or withdrawal. If client is experiencing breakthrough cravings or withdrawal, manage appropriately (see Box 32)
3. For clients who are showing signs of major instability, individual client circumstances should be considered
   - Appropriate responses may include:
     - Reassessing dose (i.e., extended-release buprenorphine maintenance dose, supplemental bup/nlx dose), especially if the client is reporting cravings or withdrawal
     - Providing referrals to adjunct psychosocial and community-based supports as appropriate
4. If doses have been missed, follow missed doses protocol (see Box 35)

Box 11. Laboratory and Point-of-Care Tests

1. RNs/RPNs CP-OUD may order a number of laboratory and point-of-care (POC) tests to support decision-making and for health promotion in OUD care
2. These tests may be ordered at baseline and at follow-up
3. See Appendix 2 for a list of these tests and information on when to consult with an MD/NP and Box 7 for considerations for bup/nlx, extended-release buprenorphine, and hepatic function

Box 12. Documentation

Documentation when following this DST should include:

1. Adherence to BCCNM Documentation Standards
2. Baseline assessment, BPMH, and PharmaNet review
3. Medication (i.e., prescribed, dispensed, administered) to include formulation, dose, route of administration, frequency, indication, duration, and client education
4. Follow-up plan
5. Other relevant information for the care team
6. Any consultation or referral done in relation to the client's care
7. The rationale for prescribing decisions, particularly those that are outside the indication in the product monograph

Example subjective, objective, assessment, plan (SOAP) note:

8. Subjective
   - Client report including:
     - Substance use and treatment history
     - Reasons for any missed dose(s)
     - Symptoms and mood
   - Collateral information from the team or family
9. Objective
   - Best Possible Medication History and PharmaNet review
   - Lab test results and POC results if applicable (including UDT)
   - Vital signs
   - Take-home doses: monitoring (e.g., UDT)
   - Physical and mental status assessment
   - Client's general appearance (e.g., acutely intoxicated, injection marks, diaphoresis, tremors)
10. Assessment
    - Clinical impression and diagnosis (e.g., OUD: client unstable as evidenced by ongoing unregulated opioid use)
11. Plan
    - Consultation related to the client's care
    - Treatment plan:
      - Interventions: medications dispensed, administered, or prescribed, including full order information drug name/formulation, dose, route of administration, frequency, indication, and length of prescription
      - The treatment plan for resuming medication after missed doses
      - Take-home doses: rationale to initiate take-home doses, confirmation the client criteria have been met
      - Any referrals
      - Client education and other interventions as appropriate
      - Follow-up plan
      - Any changes such as increased doses, decreased doses, or missed doses must be documented on PharmaNet using the transaction medication update (TMU) by end of the clinic day or shift if the facility has implemented the Integrated Interdisciplinary Model of Opioid Agonist Treatment

Box 13. Acting on an RNs/RPNs CP-OUD Order

1. In some health care settings where bup/nlx and extended-release buprenorphine are ward stock, prescribing, dispensing, and administering bup/nlx and extended-release buprenorphine may occur
2. RNs/RPNs CP-OUD are authorized to give client-specific orders that other nurses (licensed practical nurses, RNs, RPNs) are permitted to act on for dispensing or administering bup/nlx and extended-release buprenorphine. RNs/RPNs CP-OUD would follow the **BCCNM Giving Client-Specific Orders standard** (RN, RPN) . Nurses acting on a client-specific order from RNs/RPNs CP-OUD would follow the **BCCNM Acting with Client-specific Orders** standard (RN, RPN), along with their organizations policies.

Box 14. Safety Considerations

1. Prescribers are encouraged to inform and remind their clients that they should not drive or operate machinery while intoxicated or sedated by any substance, including during OAT initiation and dose increases. Refer to *A Guideline for the Clinical Management of Opioid Use Disorder (2023)* for more information.
2. Clinicians are required to report clients who have continued to drive, against clear clinician advice, if they have a medical condition that, in the clinician's opinion, makes it dangerous to drive
   - Includes active substance use disorders that would affect safe driving
   - See *Canadian Council of Motor Transport Administrators Medical Standards*
3. RNs/RPNs CP-OUD are encouraged to consider the following policies, standards, bylaws, and resources:
   - The BCCNM *Privacy and Confidentiality Practice Standard*
     - If nurses are concerned that a client poses a risk of harm to themselves or others, report it immediately to an appropriate person and follow any relevant organizational policies, procedures, or restrictions.
   - The BCCNM *Bylaw 183 Disclosure of Client Personal Information*
     - A registrant must maintain confidentiality of personal information about a client, and may disclose personal information about a client only:
       - If the registrant believes on reasonable grounds that there is a risk of significant harm to the health or safety of any person and that the use or disclosure of the information would reduce that risk
   - Organizational and employer policies
     - RNs/RPNs CP-OUD can consult an MD/NP for guidance if needed within organizational pathways and discuss concerns with leadership and risk management, if applicable

Buprenorphine/naloxone

Need to Know

This section provides more detailed information on RN/RPN CP-OUD prescribing of bup/nlx. Buprenorphine/naloxone is intended to be used in conjunction with psychosocial interventions and harm reduction education. Additional information is provided on when to consult or refer.

Required Education

RNs/RPNs CP-OUD must complete POATSP: RNs & RPNs: as required education to administer Buprenorphine/naloxone.

Box 15. Medication Education

Prior to initiation, discuss treatment options, including the risks and benefits of treatment, potential side effects, and relevant drug–drug interactions. For traditional inductions, whether office or home-based, provide education on precipitated withdrawal and how to prevent it.

Medication Education

1. All clients should receive the following information about taking bup/nlx:
   - The tablet needs to fully dissolve under the tongue to work properly—**it will not be absorbed if swallowed**
   - Do not eat, drink, or smoke while the tablet is dissolving
   - It may take 10–15 minutes for the tablet to dissolve
   - The naloxone in the medication is not active if taken under the tongue, but may cause withdrawal symptoms if the medication is crushed and snorted or injected
2. Provide educational materials to the clients as needed
   - See Appendix 3 for additional resources

Box 16. Considerations for Traditional Induction

1. The risks and benefits of all induction options should be discussed with the client to support informed decision-making

Table 2. Risks and Benefits of a Traditional Induction

	Benefits	Risks
Traditional Induction	• Clients can typically reach a therapeutic dose within 1–2 days of medication initiation • May be preferable if there has been a significant period of time since the client's last opioid dose • May be preferable if the client is experiencing significant withdrawal symptoms • May be preferred by clients who have previous experience with traditional bup/nlx induction	• May not be preferred by clients who currently use fentanyl or other intermediate- and long-acting opioids (e.g., methadone) • Risk of precipitated withdrawal if the client does not wait a sufficient amount of time after their last opioid use

2. Clients should be in moderate withdrawal before starting bup/nlx (i.e., COWS score greater than 12, Subjective Opiate Withdrawal Scale (SOWS) score greater or equal to 17)
3. For office inductions: Clients should begin induction early in the day to allow enough time for dose titration throughout the day, if possible

Table 3. Suggested Wait Time After Last Opioid Use

Medication	Suggested Wait Time
Heroin, oxycodone, hydromorphone	At least 12 hours
Slow-release oral morphine, fentanyl (confirmed, suspected, or uncertain)	At least 24 hours
Methadone	At least 48–72 hours

Box 17. Assessing Risk of Precipitated Withdrawal

1. There may be a higher risk of precipitated withdrawal with traditional inductions, compared to low-dose inductions
2. To minimize the risk of precipitated withdrawal during traditional inductions, ensure the appropriate amount of time has passed since last opioid use (see Box 16)
3. Clients who use fentanyl are at a higher risk of precipitated withdrawal
   - Start these clients at 2mg/0.5mg bup/nlx
4. For clients at a lower risk of precipitated withdrawal (e.g., recently completed withdrawal management, known time of last opioid use, fentanyl-negative UDT), consider a higher starting dose of 4mg/1mg bup/nlx

Table 4. Recommended Initial Bup/nlx Doses Based on Risk of Precipitated Withdrawal

Indication	Starting Dose	Total Starting Dose
Concern about precipitated withdrawal	One 2mg/0.5mg bup/nlx tablet	2mg/0.5mg bup/nlx
Low risk of precipitated withdrawal	Two 2mg/0.5mg bup/nlx tablets	4mg/1mg bup/nlx

Box 18. Considerations for Home Induction

1. Where safe and appropriate, RNs/RPNs CP-OUD can consider unobserved traditional induction or home induction as a means of addressing office attendance barriers and avoiding unnecessary disruptions to clients' daily lives (e.g., work, school, child-care, disability)
2. Prior to a home induction, RNs/RPNs CP-OUD should ideally be able to provide regular follow-up and support via telephone or video within regular clinic hours
    - Clients with previous experience taking bup/nlx may require less intensive support
3. Prior to initiating bup/nlx, discuss the risks and benefits of a home induction and document and obtain informed consent from the client
4. Provide clients with office contact information and in-person education and written instructions for dosing and timing, including the use of the SOWS to assess withdrawal symptoms and determine when to start induction, if appropriate
    - Instructions should include:
        - See Box 15 for client education on how to take bup/nlx
        - Wait until moderate withdrawal occurs to prevent precipitated withdrawal (SOWS score greater or equal to 17 and sufficient time has passed since last opioid use)
        - Do not use opioids during initiation to relieve symptoms
        - Do not use sedatives during initiation (e.g., alcohol, benzodiazepines, or z-drugs)
        - Do not give up if symptoms persist after the initial doses
        - After taking 4 or more tablets, most people will start feeling improvement in withdrawal symptoms
        - Return to care (specialist, family physician, NP, emergency department, nursing station, or health care setting) if symptoms of precipitated withdrawal or other adverse reactions develop and you are unable to cope
5. Instruct clients and caregivers to contact the office immediately in the event of any problems and to come in for clinical assessment as required
6. Provide the client with an education handout

Box 19. Considerations for Low-dose Inductions

1. Literature on low-dose bup/nlx is limited, but growing evidence and clinical experience in BC highlight the important role of this approach
2. Low-dose inductions may be preferred by clients who currently use fentanyl or other intermediate- and long-acting opioids (e.g., methadone)
3. Low-dose inductions are usually started in a home setting, but the initial dose may be given in a health care setting
4. Clients are not required to stop opioid use or be in withdrawal before beginning a low-dose induction
5. The client slowly up-titrates low doses of bup/nlx while continuing prescribed or unregulated full-agonist opioid use until a therapeutic dose is reached, which typically occurs in community settings over 5–10 days
6. Clinicians may use clinical judgment as to whether their client requires a longer or shorter low-dose induction period
7. Clients may be prescribed a full agonist with their low-dose induction (see Box 20)
8. Follow the considerations above for low-dose home inductions, including:
   - Providing regular follow-up and support
   - Discussing risks and benefits
   - Obtaining consent
   - Providing clients with clinic information
   - Providing verbal and written instructions for dosing and timing, taking the medication correctly, and contacting the clinic if there are any problems during the induction
9. A sample low-dose induction protocol is outlined in Table 5 below. However, the low-dose induction protocol twice a day (BID) (Table 6) may be preferred by some individuals due to the consistent twice-daily schedule

Table 5. Sample Low-dose Induction Protocol

Day	Buprenorphine/naloxone dose	Other Opioids
1	0.5mg/0.125mg bup/nlx BID	Continue use
2	0.5mg/0.125mg bup/nlx TID	Continue use
3	1mg /0.25mg bup/nlx BID	Continue use
4	2mg /0.5mg bup/nlx BID	Continue use
5	2mg /0.5mg bup/nlx TID	Continue use
6	4mg /1mg bup/nlx TID	Continue use
7	12mg /3mg bup/nlx daily	Stop use

Table 6. Sample Low-dose Induction Protocol BID

Day	Buprenorphine/naloxone dose	Other Opioids
1	0.5mg/0.125mg BID	Continue use
2	1mg/0.25mg BID	Continue use
3	2mg/0.5mg BID	Continue use
4	3mg/0.75mg BID	Continue use
5	4mg/1mg BID	Continue use
6	6mg/1.5mg BID	Continue use
7	8mg/2mg BID	Continue use
8	16mg/4mg daily	Stop use

Box 20. Full Agonist Co-prescription with Low-dose Inductions

1. If clinically indicated, co-prescribing a full agonist (e.g., methadone or SROM) during a low-dose induction can help reduce or eliminate clients' reliance on the unregulated drug supply and reduce the risk of drug poisonings while titrating bup/nlx
2. Clients may be prescribed either methadone or SROM with a low-dose bup/nlx induction
3. When co-prescribing a full agonist (either methadone or SROM), it is **out of scope** for RNs/RPNs CP-OUD to titrate the full agonist
4. Methadone and SROM are full agonists at the mu-opioid receptor, which means that no wash-out period is required
5. Doses for methadone and SROM are dependent on the client's opioid tolerance (e.g., a client with a known very high tolerance may be prescribed 300mg of SROM). More information on full agonist dosing can be found in the *Decision Support Tool for Registered Nurses Opioid Use Disorder Certified and Registered Psychiatric Nurses Opioid Use Disorder Certified Prescribing of Methadone and Slow-release Oral Morphine* and the *Guideline for the Clinical Management of Opioid Use Disorder (2023)*

Table 7. Sample Full Agonist Co-prescription with Low-dose Bup/nlx Induction for a Client with a Known Tolerance

	Methadone		SROM		Buprenorphine/naloxone
Day 1	30mg by mouth (PO) daily		200mg PO daily		0.5mg/0.125mg BID
Day 2	30mg PO daily		200mg PO daily		1mg/0.25mg BID
Day 3	30mg PO daily		200mg PO daily		2mg/0.5mg BID
Day 4	30mg PO daily	**OR**	200mg PO daily	**AND**	3mg/0.75mg BID
Day 5	30mg PO daily		200mg PO daily		4mg/1mg BID
Day 6	30mg PO daily		200mg PO daily		6mg/1.5mg BID
Day 7	30mg PO daily		200mg PO daily		8mg/2mg BID
Day 8	stop		stop		12mg/3mg BID
Day 9 and onwards	stop		stop		24mg/6mg once daily (OD)

Box 21. Managing Precipitated Withdrawal During Bup/nlx Induction

1. Explain to the client what has occurred
2. Discuss the options below for management, taking into consideration the client's preference
3. Call the 24/7 Line at 778-945-7619
4. Obtain informed consent for the agreed-upon option
5. Prescribe, administer, or dispense non-opioid adjuncts to treat withdrawal symptoms (e.g., clonidine, acetaminophen, dimenhydrinate, loperamide)

Option 1: Continue induction

- Administer additional doses of 2mg/0.5mg bup/nlx every 1–2 hours
- Continue up to the Day 1 maximum (16mg/4mg bup/nlx) or until withdrawal symptoms are resolved

Option 2: Delay induction

- Consider waiting a few hours to allow the full agonist to clear opioid receptors before administering the next bup/nlx dose
- Prescribe, administer, or dispense non-opioid adjuncts to treat withdrawal symptoms as needed
- Continue until withdrawal symptoms are resolved

Option 3: Stop induction

- Provide reassurance that symptoms will resolve as opioid withdrawal runs its course
- Offer to discuss a plan for a future induction attempt or an alternate form of OAT

Option 4: High-dose bup/nlx (out of scope for RNs/RPNs CP-OUD)

- Involves treating precipitated withdrawal with additional doses of bup/nlx in close succession, typically ranging from 8mg/2mg to 16mg/4mg
- **Refer** to MD/NP. This option is based on clinical experience and therefore some prescribers may not be comfortable with this approach

Note: Precipitated withdrawal should not occur during the transition from bup/nlx to extended-release buprenorphine if performed correctly

Box 22. Medications to Alleviate Withdrawal Symptoms

Prior to the first dose or during the first few doses of bup/nlx, consider prescribing, administering, or dispensing non-opioid adjunct medications to prevent or alleviate opioid-related withdrawal symptoms

Table 8. Non-opioid Adjuncts Used to Alleviate Withdrawal Symptoms

	Assessment	Indications	Dosage
Clonidine	• Substance use history • Opioid withdrawal symptoms • Check blood pressure and avoid if the client is hypotensive	• Mild to moderate symptoms of opioid withdrawal or precipitated withdrawal such as sweating, hot flashes, watery eyes, restlessness, anxiety	• 0.1–0.2mg PO every 6 hours PRN • Maximum 0.8mg/day
Acetaminophen	• Substance use history, planned OAT induction • Pharmaceutical and therapeutic suitability, as well as individual preference and age	• Mild to moderate pain or headache related to opioid withdrawal or precipitated withdrawal	• 325–1000mg PO every 4 to 6 hours PRN • Maximum 4,000mg/day; 2,000mg for older adults or those with liver impairment
Dimenhydrinate	• Substance use history, planned OAT induction • Assess for hypovolemia (dark yellow urine, decreased urine output, decreased skin turgor, thirst, tachycardia, hypotension, dry mucous membrane, new onset of confusion and/or delirium, lethargy) • If unable to maintain adequate hydration status or currently exhibiting signs of hypovolemia, **refer** to an MD/NP	• Treatment and prevention of nausea and vomiting related to opioid withdrawal or precipitated withdrawal	• 50–100mg PO every 6 hours PRN • Maximum 400mg/day
Ibuprofen	• Substance use history, planned OAT induction • Pharmaceutical and therapeutic suitability, as well as individual preference and age	• Mild to moderate pain or headache related to opioid withdrawal or precipitated withdrawal	• 400mg PO every 4 hours PRN • Maximum 3,200mg/day
Loperamide	• Substance use history, planned OAT induction • Assess for hypovolemia • If unable to maintain adequate hydration status or currently exhibiting signs of hypovolemia, **refer** to an MD/NP	• Sudden onset of diarrhea related to opioid withdrawal or precipitated withdrawal	• 2–4mg PO every 6 hours PRN • Maximum 16mg/day

Box 23. Assessing Clients who have Missed Doses

1. Review BPMH and PharmaNet
2. Ask the client if they have missed bup/nlx doses
   - If the client reports missing doses, ask the client empathetically why they have missed doses
   - Clients who report missed doses may require additional support (e.g., consider take-home dosing if DWI is a barrier due to employment or school)
3. Ask the client about any ongoing substance use
4. Ask for UDT, if clinically indicated
5. Document findings
6. Inform other members of the client's care team
7. If the client is pregnant, **consult** another prescriber before restarting. If the client has severe hepatic dysfunction, RN/RPN CP-OUD must **consult** before the restart
8. Follow the missed dose protocol below in Table 9
9. The pharmacist will cancel the prescription after 6 missed doses (without return to full agonist use) and after 4 missed doses (with return to full agonist use)

Table 9. Missed Doses of Bup/nlx

Missed days (consecutive)	Suggested dose adjustment
Without return to full opioid agonist use	
5 or fewer	No change in dose is required
6 or more	Re-titration is required, hold bup/nlx dose pending virtual or in-person assessment
With return to full opioid agonist use	
1–3	No change in dose is required, it is likely safe to continue bup/nlx without re-induction
4	Hold dose pending virtual or in-person assessment and discuss the risk of precipitated withdrawal and weigh the risks against the benefits of continuing bup/nlx
5 or more	Hold dose pending virtual or in-person assessment, new induction may be required (see Box 16 for traditional induction and Box 19 for low-dose induction)

Alternate day schedule

- For missed doses with an alternating day schedule, follow missed doses protocol above. Individuals should be returned to a daily dose schedule, possibly at a lowered dose, to re-stabilize prior to resuming an alternating day schedule.

Box 24. Considerations for Take-home Doses of Bup/nlx

1. Take-home dosing should be considered for all clients who meet the following criteria:
   - Clinical and psychosocial stability
     - Generally, the indications of clinical and psychosocial stability include:
       - Ability to attend appointments
       - Absence of unstable psychiatric comorbidities (e.g., psychosis, suicidality)
       - Absence of severe behavioural issues at the clinic
       - Absence of severe sedation
       - Absence of high-risk or uncontrolled substance use patterns that cause frequent drug poisoning or blackouts
     - Point-of-care assessment of stability is client-specific, depending on each client's circumstances and needs and how they change over time
   - Ability to safely store medication (access to a secure lockbox or cabinet)*
2. Take-home dosing may be considered immediately for clients who meet the criteria

* Discuss the importance of keeping the medication safe and avoiding misplacing the medication with those who do not have access to a secure lockbox or cabinet (e.g., people experiencing homelessness).

Box 25. Considerations for Bup/nlx Taper

Evidence supporting best practices for OAT tapering is lacking

1. Due to the high likelihood of the client's return to unregulated opioid use, OAT tapers are generally not recommended
2. However, if the client requests a taper following a sustained period of stability on OAT (12 months or more), then a gradual tapering regimen over months to years is recommended
3. If a client requests a bup/nlx taper:
   - **Consult** an MD/NP
   - Listen to the client's concerns and rationale for requesting the taper
   - Provide education as needed, and counsel the client on the risks of returning to substance use and drug poisoning
   - Offer information on harm reduction strategies including access to take-home naloxone, and support and referrals to appropriate services
   - Encourage the client to connect with their prescriber if concerns of substance use arise
   - A relapse prevention plan should be collaboratively developed and implemented after a discussion with the client

Extended-release Buprenorphine (Sublocade)

Need to Know

This section provides more detailed information on RN/RPN CP-OUD prescribing of extended-release buprenorphine. Extended-release buprenorphine is intended to be used in conjunction with psychosocial interventions and harm reduction education. Additional information is provided on when to consult or refer.

Required Education

POATSP: RN & RPN. CP-OUD RNs and RNs need to take the extended-release Buprenorphine module in this course to be able to prescribe and administer extended-release Buprenorphine

Indivior Sublocade Certification Prescribing Course: 15-minute online course on how to prescribe and administer extended-release Buprenorphine (Sublocade), and how to become familiar with warnings, precautions, and safety information. The learner will complete a certification quiz at the end of the program, with successful completion allowing the learner to prescribe.

BCCSU Practical Administration of Sublocade Injection online course (UBC CPE): A 45-minute course on the practical administration of Sublocade, accredited for 0.75 CEUs. Relevant for healthcare providers administering extended-release subcutaneous Buprenorphine for the management of opioid use disorder. This course provides a brief introduction to product storage considerations, a step-by-step guide to subcutaneous injection, and patient-specific considerations.

Box 26. Medication Education

1. Prior to initiation, discuss treatment options, including the risks and benefits of treatment, and potential side effects, and relevant drug–drug interactions. Provide educational materials to the client as needed (Appendix 3 for additional resources).

Medication Education

2. All clients should receive the following information about taking extended-release buprenorphine:
   - It is administered subcutaneously in the abdominal area every month by a physician, nurse, or pharmacist
   - Daily bup/nlx therapeutic dose will be discontinued or tapered after first dose of extended-release buprenorphine
   - A solid lump may form at the injection site following administration. This may last for several weeks and will decrease in size over time
   - Breakthrough withdrawal and cravings may occur while taking extended-release buprenorphine, particularly at the start of treatment. Supplemental bup/nlx may be provided to help manage these symptoms
   - Pain management may be administered prior to the injection, if the client is interested (see Box 30 for more information)
   - After administration, there may be pain or itching at the injection site. Advise the client to not rub or massage the injection site. Refer to Box 30 for more information

Box 27. Extended-release Buprenorphine Inductions

1. Clients should be stabilized on 8mg/2mg–32mg/8mg bup/nlx for a minimum of 7 days before transitioning to extended-release buprenorphine. A more rapid transition to extended-release buprenorphine may be appropriate for some clients (see to Box 28)
   - For clients stabilized on >32mg/8mg bup/nlx, RNs/RPNs CP-OUD must **consult** an MD/NP, the 24/7 Line, or the organizational pathway
   - Follow traditional or low-dose induction protocols for bup/nlx (see Box 16 and Box 19, respectively)
2. Prescribe initial dose of 300mg/1.5mL per month for 1 month
3. At least 26 days after the initial dose, administer second dose
   - Prescribe 300mg/1.5mL, except for:
     i. Clients who have been stabilized long-term on <18mg/4.5mg bup/nlx **prior** to transitioning to extended-release buprenorphine
        a. Prescribe 100mg/0.5mL dose
4. After the first 2 months, prescribe a maintenance dose (see Box 33 for more information):
   - 100mg/0.5mL per month
   - 300mg/1.5mL per month (RNs/RPNs CP-OUD must **consult** with an MD/NP or the 24/7 Line)
5. There must be a minimum of 26 days between doses

Box 28. Considerations for Rapid Inductions

1. A more rapid induction to extended-release buprenorphine (i.e., transitioning to extended-release buprenorphine after fewer than 7 days on bup/nlx) may be appropriate for some clients
2. RNs/RPNs CP-OUD **must consult** with an MD/NP or the 24/7 Line before initiating a rapid induction and at any point if decision making is unclear or uncertain

Box 29. Pharmacy Requirements and Coordination for Dispensing Extended-release Buprenorphine

1. When determining the timing of an extended-release buprenorphine induction, RNs/RPNs CP-OUD should contact the pharmacy to inquire about the availability of the medication, how long it takes to have the medication ready for delivery/pick-up, and proper storage of the medication.
2. RNs/RPNs CP-OUD must directly communicate with the pharmacy to arrange the pick-up and transportation of the extended-release buprenorphine injection. The injection must be picked up and transported to the clinic by a health care provider (either a nurse or an MD/NP), or delivered to the clinic; **clients are not permitted to perform this task.**
3. RNs/RPNs CP-OUD must create a plan with the pharmacy in advance for each extended-release buprenorphine prescription, and should clarify the following information:
    - What day the prescription be dispensed and picked-up
    - If the prescription will be picked up by a health care provider, and who this individual will be
    - If the prescription is being delivered, what is the delivery address
4. RNs/RPNs CP-OUD should be aware that pharmacies are advised to stock only the amount of extended-release buprenorphine needed to avoid overstocking. Having clear communication with the dispensing pharmacy is crucial in ensuring the medication will be available in a timely manner.
    - Ensure the client will have access to a pharmacy that has extended-release buprenorphine within the timeframe needed, as pharmacies generally only have enough extended-release buprenorphine in stock for current clients

Box 30. Managing Injection Site Pain and Side Effects

The client may request pain management prior to the administration of the extended-release buprenorphine dose:

1. Ice pack applied to their abdominal area
2. Acetaminophen 650mg PO
3. A lidocaine injection 20–30 minutes before medication administration
    - RNs/RPNs CP-OUD may only administer lidocaine before an extended-release buprenorphine injection if they are acting on a client-specific order from the prescribing MD/NP and in accordance with organizational policies and protocols

Managing the injection site after extended-release buprenorphine administration:

1. Ask client to avoid rubbing or massaging injection site
2. Over-the-counter medication such as acetaminophen and ibuprofen may be taken for pain
3. Advise the client to seek follow-up care if they have a rash, itchiness, or pain that persists or worsens post injection
4. A severe injection site reaction may present as a fever greater than 38°C (100.4°F), redness, pain, swelling, purulent discharge, or ongoing bleeding. Advise the client to seek follow-up care

Box 31. Medication Administration of Extended-release Buprenorphine

1. Medication is to be stored in fridge upon arrival at site. Follow organization's procedures for storage, receipt, and maintenance of controlled drugs and substances.
2. Remove medication from the refrigerator at least 15 minutes prior to administration to allow it to reach room temperature.
3. Administer pain relief prior to administration if client requests (see Box 30).
4. Inspect the liquid clarity of the medication to make sure it does not contain any contaminants. Extended-release buprenorphine ranges from colourless to yellow to amber.
5. For detailed information on the administration of extended-release buprenorphine, follow the directions in the product monograph and the Practical Administration of Sublocade Injection course by the BCCSU and the UBC Continuing Pharmacy Professional Development program. Administer extended-release buprenorphine subcutaneously in the abdomen where the skin does not have any conditions such as irritation, redness, bruising, infection, or scarring. **Do not inject extended-release buprenorphine intravenously or intramuscularly.**
   - Ensure the client is in the supine position prior to medication administration
   - Choose an injection site that is between the transpyloric and transtubercular planes with enough subcutaneous tissue
   - Pinch the injection site prior to administering the injection
   - It is crucial that the RN/RPN CP-OUD has received education and training on the proper administration of the extended-release buprenorphine injection, to ensure proper absorption of the medication and to maintain client health and comfort. Please see required and optional education on page 45
6. Document site administration of extended-release buprenorphine (e.g., upper right quadrant) and other relevant information. Rotate injection sites each month to avoid irritation.
7. Discard extended-release buprenorphine if left at room temperature for longer than 7 days. Return to pharmacy or follow organization's disposal policy.

Box 32. Prescribing Supplemental Bup/nlx PRN to Address Breakthrough Withdrawal

1. Explore contributors to breakthrough withdrawal (e.g., physical versus psychological)
2. Clients may experience withdrawal symptoms or cravings:
   - During initiation and titration
   - Consistently, irrespective of treatment status
3. If the client experiences withdrawal symptoms or cravings while on extended-release buprenorphine consider prescribing supplemental doses of bup/nlx PRN (maximum 8mg/2mg bup/nlx per day) as appropriate
4. If the client requires more than 8mg/2mg bup/nlx PRN, **consult** an MD/NP, the 24/7 Line, or the organizational pathway and document this consultation
5. The client may require fewer supplemental doses of bup/nlx PRN after the second dose. However, some individuals may continue to need supplemental bup/nlx PRN for an extended period to manage withdrawal symptoms. This should be evaluated on a case-by-case basis depending on each individual's needs.

Box 33. Determining Extended-release Buprenorphine Maintenance Dose

1. Consider if there are any indications that a 100mg/0.5mL maintenance dose may be insufficient (e.g., a combination of 2 or more of the following: high bup/nlx stabilization dose, frequent use of supplemental bup/nlx PRN, IV opioid use prior to bup/nlx induction, significant cravings after second extended-release buprenorphine injection, or clinical instability on a 100mg/0.5mL maintenance dose)
   - If there are any indications that a higher maintenance dose may be required, **consult** with an MD/NP or the 24/7 Line before prescribing a maintenance dose of 300mg/1.5mL
2. If there are no indications that a higher maintenance dose is necessary, prescribe a 100mg/0.5mL maintenance dose. Assess whether the individual shows a satisfactory clinical response to the 100mg/0.5mL dose
   - If the individual displays a satisfactory response, continue with 100mg/0.5mL maintenance dose
   - If the client does not demonstrate a satisfactory clinical response, **consult** with an MD/NP or the 24/7 Line to determine if a 300mg/1.5mL maintenance dose should be trialed
3. Individuals who have been stabilized on 8mg/2mg–18mg/4.5mg bup/nlx for a period of time may be transitioned to a 100mg/0.5mL maintenance dose after receiving only 1 initial 300mg/1.5mL dose of extended-release buprenorphine

Box 34. Assessing Clients who have Missed Doses of Extended-Release Buprenorphine

1. Up to 2 weeks delay in monthly injection: Administer the dose as soon as possible. The next dose should be scheduled a minimum of 26 days after
2. More than 2 weeks delay: RNs/RPNs CP-OUD must **consult** with an MD/NP, the 24/7 Line, or organizational pathway for guidance around re-induction
3. Ask the client about any ongoing substance use
4. Perform UDT, if clinically indicated
5. Inform other members of the client's care team

Box 35. Considerations for Extended-release Buprenorphine Discontinuation

1. Discontinuing OAT is not recommended as there is a high risk of drug poisoning when an individual discontinues OAT and returns to unregulated opioid use
2. If a client is interested in discontinuing extended-release buprenorphine, client should be monitored for several months for signs and symptoms of withdrawal
3. Therapeutic levels of buprenorphine remain in the body for approximately 2–5 months, depending on dosage and number of doses received. Clients who have discontinued extended-release buprenorphine may have buprenorphine detectable in plasma and urine at subtherapeutic levels for several months
4. Clients who are interested in discontinuing extended-release buprenorphine should be offered another OAT medication
    - Transition to bup/nlx:
        - **Consult** with an MD/NP, the 24/7 Line, or organizational pathway
        - Provide 4mg/1mg of bup/nlx when next injection would have been due
        - Titrate bup/nlx weekly based on withdrawal symptoms
    - **Transition to methadone or SROM:**
        - **Consult** with a MD/NP, the 24/7 Line, or organizational pathway
        - Transitions to a full agonist are challenging and can be unpredictable

Box 36. Other Considerations for Extended-release Buprenorphine

1. See Box 5 Co-occurring CNS Depressants
2. See Box 6 Considerations for Bup/nlx and Extended-release Buprenorphine Prescribing in Pregnancy
3. See Box 7 Considerations for Clients with Poor Hepatic Function
4. See Box 8 Considerations for Bup/nlx and Extended-release Buprenorphine Prescribing for Youth
5. See Box 11 Laboratory and Point-of-Care Tests
6. See Box 12 Documentation
7. See Box 13 Acting on an RN/RPN CP-OUD Order
8. See Box 14 Safety Considerations

Appendix 1: Drug—drug Interactions

It is the responsibility of the RN/RPN CP-OUD to stay up to date with drug–drug interactions (e.g., by using UpToDate or other approved reference material).

Common drug–drug interactions			
Category	Examples	Comment	Action for RNs/RPNs CP-OUD
Alcohol	Medications containing alcohol (e.g., liquid formulations of cold medicine)	The additive depressant effect increases the risk of respiratory depression, profound sedation, coma, and death	**Consult** if there has been new alcohol use since the last prescription **Consult** if there is ongoing use and the client is clinically unstable (e.g., increased sedation, intoxication), if CNS depressant use has changed significantly in terms of substance, frequency, or dose, and prioritizing client safety See Box 1 for alcohol use or AUD
Anticholinergics	Diphenhydramine Brompheniramine Dimenhydrinate Doxylamine	Theoretical increase in the risk of urinary retention and severe constipation, which can lead to paralytic ileus	Monitor the client for signs of urinary retention or reduced gastric motility that does not improve with the administration of sennosides **Consult** with an MD/NP for assessment and diagnosis
Central nervous system depressants	Antiemetics Antihistamines Antipsychotics Anxiolytics Benzodiazepines and z-drugs General anesthetics Muscle relaxants Neuroleptics Other opioids Phenothiazines Sedatives/hypnotics Tranquilizers	The additive depressant effect increases the risk of respiratory depression, profound sedation, coma, and death	**Consult** for initiations, continuations, restarts, or titrations if new CNS depressant use or significant changes in client's status **Refer** for initiations if the client has a sedative use disorder
Cytochrome P450 3A4 (CYP3A4) inhibitors	Azole antifungals Macrolide antibiotics Protease inhibitors	May increase the plasma concentration of buprenorphine, resulting in prolonged opioid effects May require buprenorphine dose reduction or a change in antibiotic or antifungal medication	Closely monitor the client for respiratory depression and sedation **Consult** with pharmacy or other resources prior to prescribing if uncertain **Refer** client to another provider if change in antibiotic or antifungal required
CYP3A4 inducers	Carbamazepine Phenobarbital Phenytoin Rifampin	May decrease the plasma concentration of buprenorphine, resulting in under treatment of OUD. The individual may experience withdrawal symptoms May require dose adjustment of CYP3A4 inducer or buprenorphine	Closely monitor the client for potential under-dosing and symptoms of opioid withdrawal **Consult** with pharmacy or other resources prior to prescribing if uncertain

Common drug–drug interactions			
Category	Examples	Comment	Action for RNs/RPNs CP-OUD
Opioid antagonists and mixed agonist/ antagonist	Naltrexone	**Contraindicated** Reduces or completely blocks the pharmacological effects of buprenorphine, which can lead to precipitated withdrawal	Check PharmaNet for opioid antagonist prescriptions The client may require a different medication (e.g., acamprosate for AUD). **Refer** client to an MD/NP if a different prescription is needed
QTc Interval-Prolonging Drugs	Class IA antiarrhythmics Class III antiarrhythmics Class 1C antiarrhythmics Antipsychotics Antidepressants Opioids Macrolide antibiotics and analogues Quinolone antibiotics Pentamidine Antimalarials Azole antifungals Domperidone Anagrelide Ivabradine 5-hydroxytryptamine receptor antagonists (5-HT3) Tyrosine kinase inhibitors Arsenic trioxide Histone deacetylase inhibitors Beta-2 adrenoceptor agonists	Although mixed results have been reported in the literature, there is no clear association between buprenorphine and QTc prolongation However, individuals who have a pre-existing risk of prolonged QT interval (e.g., baseline QT prolongation, concomitant use of QT-prolonging medications) may experience additive effects	Closely monitor the client for QTc prolongation **Refer** to MD/NP for assessment and diagnosis
Serotonergic medications	MAOIs	Theoretical increase in the risk of serotonin syndrome Concomitant use of MAOIs may exaggerate the effects of opioids	Use of bup/nlx or extended-release buprenorphine is **not advised** for individuals who are taking MAOIs or within 14 days of stopping treatment Closely monitor the client for signs and symptoms of serotonin syndrome **Refer** to MD/NP for assessment and diagnosis
	Selective Serotonin Reuptake Inhibitors (SSRI) Selective Norepinephrine Reuptake Inhibitors (SNRI) Tricyclic Antidepressants Triptans 5-HT3 receptor antagonists Drugs that affect the serotonin neurotransmitter system	Theoretical increase in the risk of serotonin syndrome	Closely monitor the client for signs and symptoms of serotonin syndrome **Refer** to MD/NP for assessment and diagnosis

Note on cytochrome P450 3A4

- Buprenorphine is metabolized by the CYP3A4 enzyme system
  - Drugs that are known to inhibit or induce CYP3A4 have the potential to diminish or enhance buprenorphine metabolism–**buprenorphine doses rarely need to be adjusted**

Appendix 2: Summary of Laboratory and POC Tests Authorized for RNs/RPNs CP-OUD to Order

Laboratory Test	Follow-up for RNs/RPNs CP-OUD
Tests Performed Prior to Initiating OAT *If performing laboratory tests prior to initiation presents a barrier to care, these tests should be ordered as soon as reasonably possible*	
Urine– Immunoassay UDT Either POC or lab-tested immunoassay	• To confirm client-reported substance use and prescribed medication • False-positives and false-negative results are possible for opioids and benzodiazepines, and false-positive results are possible for amphetamines • See *Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment: Breakout Resource* for more information; **consult** within organization pathway or the 24/7 Line
Pregnancy test	• A pregnancy test should be performed on clients of child-bearing capacity who are sexually active, to ensure the client is connected to appropriate follow-up care and to guide the treatment plan • For bup/nlx: **Consult** in the absence of a documented plan from a (perinatal) addiction medicine specialist • For extended-release buprenorphine: **Refer** clients who are or become pregnant during treatment to an MD/NP
Tests that Have Implications for OAT Care Performed prior to initiation when feasible, should not be a barrier to initiating care	
Blood Complete blood count Creatinine/ estimated glomerular filtration rate (eGFR)—serum/ plasma Prothrombin time/ INR	**Consult** MD/NP if outside the normal ranges as per organizational processes to determine a plan of care
Liver function Albumin Alanine minotransferase Gamma glutamyl transferase Bilirubin	The 24/7 Line can be consulted in the case of severe hepatic dysfunction (e.g., ALT or GGT greater than 3 times the upper limit of normal, any elevation in bilirubin) and concern around bup/nlx and extended-release buprenorphine prescribing Abnormal liver function results that are less than 3 times the upper limit of normal should not delay the prescription of bup/nlx and extended-release buprenorphine, but the client should be connected to primary care for follow-up

Tests for Health Promotion, to be Offered as Clinically Indicated Additional tests that may be appropriate following treatment initiation	
Hepatitis A, B, and C serology	• Review BC Centre for Disease Control (BCCDC) resources for interpretation of chronic and active infection • Registered nurses and RPNs who have completed the BCCDC's Immunization Competency Course can: o Use Hep A and B serology to determine client immunity o Recommend immunization where appropriate • Registered nurses and RPNs can call the BCCDC line for support with interpretation but may need to refer to another provider for management that requires treatment • Hepatitis C: o Hepatitis C virus genotype and ribonucleic acid testing should be conducted when clinically indicated to confirm current infection status and to determine the most effective treatment approach 1. See the BCCDC Hepatitis C Testing Guide: Quick Reference Guide for Health Care Practitioners o For individuals with previous exposure to hepatitis C, regularly update and review their liver health status through routine bloodwork to monitor any changes that could impact their overall health 1. Incorporate these tests as part of the initial and ongoing assessment for individuals at risk of, or diagnosed with, hepatitis C to ensure comprehensive management and care of the individual o For individuals with an active infection, liver failure, signs of clinical instability, or if there is a change in the client's presentation, **refer** to an MD/NP for diagnosis and treatment o **Note:** If RNs and RPNs order any of the tests above, they must follow up and ensure appropriate reporting of certain diseases
HIV test	Registered nurses and RPNs should complete the HIV Point of Care Testing Online Course prior to conducting POC tests or ordering HIV serology, and be familiar with organizational pathways for referrals
Sexually transmitted infections (STI)	**Gonorrhea and chlamydia (GC/CT urine or swab)** • Registered nurses Sexually Transmitted Infections Certified: can diagnose and treat within the STI-certified practice DSTs • Those without certified practice Sexually Transmitted Infections: **Refer** to an STI-certified RN, an NP, or a physician for positive test results **Syphilis serology** • For interpretation, call the BCCDC line • **Refer** to another provider for diagnosis and management that requires treatment **Note:** If RNs and RPNs order any of the tests above, they must follow up and ensure appropriate reporting of certain diseases (e.g., syphilis must be reported to BCCDC)

APPENDIX 3: ADDITIONAL RESOURCES

Resources for Health Care Providers

24/7 Addiction Medicine Clinician Support Line

To speak to an addiction medicine specialist, call 778-945-7619.

Provides telephone consultation from an addiction medicine specialist to physicians, nurse practitioners, registered nurses, registered psychiatric nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment. The 24/7 line is available to any frontline staff working in Indigenous communities in BC. Consultation can include support in screening, assessment, treatment, and management of substance use and substance use disorder(s).

BC PharmaCare: Current PharmaCare plans and drug coverage

Canadian Nurses Protective Society: A not-for-profit society that offers legal advice, risk-management services, legal assistance, and professional liability protection related to nursing practice

Clinics accepting new OAT clients: Contact information for OAT clinics across BC currently accepting new OAT clients

Day Calculator: It may be helpful to use a day calculator to determine the duration when writing prescriptions

Up to Date: Clinical decision support tool and current drug–drug interactions

Resources for Clients

Brave app: Drug poisoning detection app that is used to anonymously connect individuals who use substances to remote supervision and support

Lifeguard Digital Health: App that is activated by a person before they use opioids and alerts emergency medical dispatchers to a potential drug poisoning

Opioids: A Survivor's Guide: A handbook about the different types of OAT

Opioid Treatment Access Line: Service that provides same-day access to OAT for individuals in BC to help prevent withdrawals, reduce cravings and the risk of drug poisonings

Toward the Heart: Current listing of harm reduction services in BC that provide safer drug consumption supplies, drug poisoning prevention training, and take-home naloxone kits

Guidelines

Guidelines and Protocols Advisory Committee's OUD Induction Handout

Guideline for the Clinical Management of Opioid Use Disorder (2023): BC Provincial guideline for the management of OUD

Treatment of Opioid Use Disorder for Youth—Guideline Supplement: Focused on the management of OUD for youth (age 12–25)

Education

Practical Administration of Sublocade Injection Course: Course offered by the BCCSU and the UBC Continuing Pharmacy Professional Development program on the administration of extended-release buprenorphine

Provincial Opioid Addiction Treatment Support Program: Mandatory online training program offered by BCCSU and UBC CPD for prescribing OAT in BC

Sublocade Certification Course: Course completion required by Indivior before prescribing extendedrelease buprenorphine

Appendix 4: Abbreviations

5-HT3: 5-hydroxytryptamine
ALT: alanine aminotransferase
BCCDC: British Columbia Centre for Disease Control
BID: twice a day
BPMH: best possible medication history
Bup/nlx: buprenorphine/naloxone
CNS: central nervous system
COPD: chronic obstructive pulmonary disorder
COWS: Clinical Opiate Withdrawal Scale
CP-OUD: Opioid Use Disorder Certified
CT: computed tomography
CYP: cytochrome
CYP3A4: cytochrome P450 3A4
DSM-5-TR: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
DST: decision support tool
ECHO: echocardiogram
ECG: electrocardiogram
EEG: electroencephalogram
eGFR: estimated glomerular filtration rate
GC/CT: Neisseria gonorrhoeae/chlamydia trachomatis
GGT: gamma glutamyl transferase
GI: gastrointestinal
INR: international normalized ratio
IV: intravenous
MAOI: monoamine oxidase inhibitor
MD: physician
MRI: magnetic resonance imaging
NP: nurse practitioner
OAT: opioid agonist treatment
OD: once daily
OUD: opioid use disorder
PO: by mouth
POC: point-of-care
PRN: as needed
SOWS: Subjective Opiate Withdrawal Scale
TID: three times a day
TMU: transaction medication update
UDT: urine drug testing
RACE: Rapid Access to Consultative Expertise
RN: registered nurse
RPN: registered psychiatric nurse
SNRI: serotonin-norepinephrine reuptake inhibitor
SSRI: selective serotonin reuptake inhibitor
STI: sexually transmitted infection
SROM: slow-release oral morphine
Z-drugs: non-benzodiazepine medications typically prescribed for insomnia (e.g., zopiclone, zolpidem, zaleplon)