FENTANYL TABLET

(PRN and Maintenance)

Prescribed Safer Supply Protocol

CLINICAL SUMMARY

BRITISH COLUMBIA
BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers
phs COMMUNITY SERVICES SOCIETY

The purpose of this clinical summary is to provide clinicians with an overview of the Fentanyl Tablet Provision PRN and Maintenance Protocols and serve as a wayfinding document to important information within the protocol.

Outline

1. Evidence Supporting Intervention (PRN, pg. 5; Maintenance, pg. 6)

Currently, there is no evidence or established best practices supporting the efficacy or safety of fentanyl tablets for mitigating risk from the toxic drug supply. There is, however, limited clinical experience demonstrating benefits for those with an opioid use disorder (OUD) that want to reduce their use of unregulated opioids.

2. Program Models (PRN, pg. 7; Maintenance, pg. 8)

Fentanyl tablet programs may be offered through regional health authority-operated/funded programs and federally funded programs (e.g., SAFER). This may include adding fentanyl tablet provision to a variety of existing programs and services, including opioid agonist treatment (OAT) clinics, injectable agonist treatment (iOAT) clinics, and overdose prevention/supervised consumption sites. There are two dosing strategies for this program: fixed dose as-needed (PRN) program and a higher dose maintenance program.

3. Eligibility (PRN, pg. 9; Maintenance, pg. 10)

It is not a requirement for individuals to have trialed OAT (oral and/or injectable) to be considered for the fentanyl tablet program; however, prescribers should explore all options with participants including evidence-based pharmacotherapy and psychosocial treatment supports, in an ongoing manner.

The following considerations for eligibility should be assessed and documented in the participant's health record:

- Active OUD diagnosis (see note below) **AND**
- Ongoing active unregulated fentanyl use **AND**
- At high risk of overdose, injection-related harms, or other harms related to the use of unregulated opioids via a detailed clinical assessment including overdose history

Note: There may be some individuals who have not been formally diagnosed with an OUD, who use unregulated fentanyl and would benefit from accessing prescribed safer supply. The PRN program may be appropriate for individuals who have not been diagnosed with OUD, based on clinical judgment and individual circumstances.

4. Drug–drug Interactions (PRN, pg. 13; Maintenance, pg. 14)

Many drugs interact with fentanyl. Prescribers should consult the product monograph and other sources for information on drug–drug interactions for any drug co-administered with fentanyl, including a pharmacist. A detailed list can be found in the Prescribed Safer Supply Protocols.

Special Caution: Antiretroviral Medication

There is a strong interaction between fentanyl and some antiretroviral (ARV) drugs used to treat HIV. Antiretroviral medications containing the "boosters" cobiscisat or ritonavir inhibit CYP3A4, which can lead to significant increases in fentanyl levels. Individuals who are stable on potentially-interacting ARV treatment may be started on fentanyl tablets and should be monitored closely for sedation. Initiating fentanyl tablets for individuals who might stop and restart potentially-interacting ARVs is not recommended. A clinician who specializes in HIV care should be consulted prior to initiating or changing ARVs.

Fentanyl tablets are not bioequivalent to other fentanyl products. Do not convert participants on a mcg per mcg basis from other fentanyl products. This includes oral, transdermal, or parenteral formulations of fentanyl.

5. Patient Education Checklist

✓	Key points
	Individuals with OUD (may not have been diagnosed), who engage in active unregulated fentanyl use, and who are at a high risk of overdose or harms are eligible for this program. The PRN program may be appropriate for individuals using unregulated fentanyl who are at high risk of overdose or harms, but may not have an OUD diagnosis.
	Fentanyl poses a significant risk for those who do not have an opioid tolerance, including other adults, children, and pets.
	You may be required to attend the clinic 2–4 times a day for witnessed doses, unless you are eligible for take-home dosing.
	At initiation and after a dose increase, 4 post-dose observations of 25 minutes over 4 consecutive days are required to ensure your safety. After that, post-dose observations are not required.
	If you experience sedation after the first dose, you are not eligible for this program.
	Tablets should not be chewed, sucked, or swallowed as it will decrease effectiveness.
	Tablets should be placed under the tongue or above a rear molar, between the upper cheek and gum, until fully dissolved which takes approximately 14–25 minutes. After 30 minutes, if pieces of the fentanyl tablet remain, they may be swallowed.
	Missed doses may require dose adjustments or restarts, talk to your prescriber if this happens.
	Avoid using downers such as alcohol or benzodiazepines as they may increase the risk of an overdose.
	Drug–drug interactions exist with HIV medications and may increase the risk of overdose.
	Let your provider know if you experience an overdose.
	Possible side effects: slowed breathing, nausea, vomiting, constipation, sores, or sensitivity in the mouth.

6. Visit Assessment and Assessment of Benefit (PRN, pg. 21; Maintenance, pg. 25)

- An initial assessment should be performed and documented prior to starting the program
- Ongoing assessments should be done at least every 2 months, depending on clinical and participant context and capacity, including:
    - An assessment of benefit that includes subjective and objective indicators (e.g., how the participant is doing, general appearance)
- Pre-dose assessments should include a subjective assessment (i.e., last dose tolerated, any concerns) and an objective assessment (SAFER Sedation Scale [SSS])
- Post-dose assessments should include dose and time of fentanyl tablet administration, SSS score post-dose, next dose, and follow up or referral to other services

7. Fentanyl Tablet Fixed-dose PRN Program

7.1 Initiation (pg. 19)

The PRN program may be desirable for individuals with lower opioid needs and/or those who do not want to undergo titration or missed dose procedures, individuals with barriers to accessibility, or those with episodic needs. Based on hours of operation and program capacity, twice daily (BID), three times daily (TID), or four times daily (QID) dosing may be appropriate. Participants receiving PRN dosing may choose to switch to the maintenance program at any point.

- Each participant will go through an observed test dose to initiate the program
- An initial dose of 800mcg will be given, followed by a 25-minute post-dose observation period
    - If there is no sedation after the first dose(s), they may continue with 800mcg Q3H as their fixed PRN dose
- Participants must continue post-dose observations for a total of 4 doses over 4 consecutive days, [a] including the initial test dose
    - After this, the participant will no longer need to stay unless they trigger the missed dose procedure

[a] Doses do not have to be consecutive (e.g., 4 doses in one day with QID dosing, or 1 dose per day over 4 days)

7.2 Missed Doses (pg. 19)

Table 1. Summary of procedures for missed doses during PRN Program

Consecutive doses missed	Procedures
During Initiation	
Any number	Continue with post-dose observations until **4 observed doses over 4 consecutive days** are achieved with no sedation 25 minutes post-dose.
After Initiation	
≥10	Notify the clinic/pharmacy/prescriber to pause current prescription. Assess participant and contact pharmacy to restart prescription. (See section 5.13 Community Pharmacy Involvement in Care and Appendix 9: Sample Service Delivery Models for more information about the potential role of community pharmacies.)
60–178	Conduct assessment (vitals, weight, point-of-care UDT, use of unregulated opioids): • If no unregulated opioid use present (i.e., due to detox, incarceration, or other factors/events): restart program at initiation, including 4 observed doses over 4 consecutive days without sedation • If unregulated opioid use present: restart program with 800mcg test dose + 25-minute post-dose observation to confirm tolerance Prescriber contacts pharmacy to re-start prescription.
≥179	Assessment by a prescriber in person to determine if the participant is benefitting from the program and/or to explore other options.

8. Fentanyl Tablet Maintenance Program

8.1 Initiation (pg. 20)

The fentanyl tablet maintenance program may be preferred by participants who require doses above 800mcg Q3H. The initial dose is 800mcg with a post-dose observation for 25 minutes, after which the participant can access an additional 200mcg if desired, followed by another post-dose observation period.

If there is no sedation after the first dose(s), the participant may begin their titration starting at 800mcg, with a minimum of 3 hours between doses, and an increase of 100mcg for each subsequent dose. Post-dose observations of 25 minutes are required after each dose during the initiation phase.

8.2 Titration Schedule (pg. 20)

There is no maximum dose for this program. All participants should be titrated from 800mcg until an effective dose is reached (e.g., once cravings and withdrawal symptoms are managed), as long as there are no complications or issues noted with sedation.

It is recommended that participants are administered the tablet combination using the fewest tablets possible, due to subtle differences in absorption and ease of administration.

Based on hours of operation and program capacity, BID, TID, or QID dosing may be appropriate. Following a dose increase, participants must stay for 4 post-dose observations over 4 consecutive days to ensure their safety. **Table 1** shows an example BID titration schedule to reach a dose of 1300mcg.

Table 1. Fentanyl Titration Schedule for Maintenance Program

Day	Procedures
1	800mcg SL (Q3H) 3 hours or more later 900mcg SL
2	1000mcg SL 3 hours or more later 1100mcg SL
3	1200mcg SL 3 hours or more later 1300mcg SL

SL=sublingual

8.3 Missed Doses (pg. 22)

Participants must have **4 doses over 4 consecutive days** with no sedation during the 25-minute post-dose observation period, after which they no longer require post-dose observation. If there are missed doses during this time, participants continue with post-dose observations until they have 4 doses in a row, with no sedation post-dose.

8.3.i Missed doses during titration (pg. 22)

If a participant misses 3 or more doses during the titration period, the titration must be started again from the beginning. Post-dose observations are always resumed when participants are titrating.

8.3.ii Missed doses during maintenance (pg. 23)

The table below applies to participants who have reached maintenance or 4 consecutive doses without sedation.

Table 2. Summary of actions for missed doses during maintenance

Consecutive doses missed	Action
Up to and including 14 doses	No change; no post-dose observation required.
15–16 doses	No dose reduction, one 10-minute post-dose observation to confirm tolerance
17–22 doses	25% dose reduction recommended, rounding dose up to the nearest 100mcg
23–28 doses	50% dose reduction recommended, rounding dose up to the nearest 100mcg
29 or more doses	Titration will restart from beginning with assessment

If participants previously achieved 4 post-dose observation periods across 4 consecutive days without sedation at maintenance, there is 1 post-dose observation after reaching maintenance. If they had not previously achieved 4 post-dose observation periods across 4 consecutive days without sedation, they must have 4 post-dose observation periods across 4 consecutive days at maintenance with no sedation (the prescriber can make a clinical judgement on a case-by-case basis to stop post-dose observation early).

8.3.iii Missed doses during re-titration (pg. 24)

This table applies to individuals who previously reached either maintenance or 4 post-dose observation periods over 4 consecutive days without sedation, had a 25–50% dose decrease due to missed doses, and then missed 1 or more doses during the re-titration phase.

Table 3. Missed doses during re-titration

Consecutive doses missed	Action	Example scenario
1–6	Continue with titration	Xio is re-titrating after a decrease to 800mcg. He received the 1000mcg dose, missed the following 6 doses, then presents to clinic. He will receive 1100mcg.
7	Repeat last dose received	Sammy received 900mcg, missed 7 doses, and presents to clinic. She will receive 900mcg and continue re-titrating at the next dose.
8–17	Decrease dose by 50%	Zee was re-titrating from 800mcg. They got up to 1800mcg, then missed 14 doses. They present to the clinic and receive 900mcg.

8.3.iv Missed doses after an increase (pg. 25)

If a maintenance participant is scheduled for a dose increase the following day, they may miss up to 4 doses and still receive the increase. If they miss 5–7 doses after a scheduled increase, the nurse will contact the prescriber for a new prescription to return to their previous dose. If the participant has missed 15 doses, they require one post-dose observation.

9. Take-home Doses (PRN, pg. 24; Maintenance, pg. 29)

Take-home doses may be considered in the following situations:

- Participant has completed titration and is displaying psychosocial and clinical stability **AND**
- Participant preference **AND**
- Participant is able to safely store medication (i.e., secure, locked container or cabinet) **AND**
- Clinical judgment

10. Documentation (PRN, pg. 23; Maintenance, pg. 27)

10.1 Integrated Interdisciplinary Model of Opioid Agonist Treatment (IIMOAT)

For programs that have implemented IIMOAT, health care professionals or delegates are to document any changes made to pharmacy-prepared patient-specific medication—such as increased doses, decreased doses, or missed doses—on PharmaNet using the transaction medication update (TMU). In cases where the patient requires a dose and the pharmacy is unable to prepare, it can be prepared by nursing and provided through clinic stock. The exceptional reason must be documented and entered in PharmaNet by using the TMU.

10.2 Safer Alternative Documentation

Prescribers are asked to add “SA” to all prescribed safer supply prescriptions to improve data collection for safer supply programs and identify unintended risks or harms. If required, pharmacists should add “SA” to prescriptions at transmission to PharmaNet.

11. Feedback and Support

As the use of fentanyl tablets is not an evidence-based approach, the BCCSU welcomes clinicians to share observations, comments, or issues based on clinical experience. Please email BCCSU Education: **bccsu_education@bccsu.ubc.ca**

Clinicians can also call the 24/7 Addiction Medicine Clinician Support Line at **(778) 945-7619** for clinical advice about substance use care and treatment.

More information on the fentanyl tablet program can be found on the BCCSU website.