cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

# Safe Prescribing for Opioid Use Disorder

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Advice to the Profession documents are dynamic and may be edited or updated for clarity at any time. Please refer back to these articles regularly to ensure you are aware of the most recent advice. Major changes will be communicated to our members; however, minor edits may only be noted within the documents.

## Contents

ADVICE TO THE PROFESSION

# Safe Prescribing for Opioid Use Disorder

## Scope

Opioid Use Disorder (OUD) is one of the most challenging forms of addiction and a major contributing factor to the recent rise in opioid-related morbidity and mortality. In recent years, the non-medical use of pharmaceutical opioids and the emergence of highly potent, illegally manufactured opioids have increasingly impacted the evolving landscape of opioid use.

OUD is best conceptualized as a chronic, relapsing illness with the potential for sustained, long-term remission with appropriate treatment. OUD can involve misuse of prescribed opioid medications, use of diverted prescribed opioid medications or use of illegally manufactured opioids, such as heroin, fentanyl or fentanyl analogues. For more information, refer to the DSM on Diagnostic Criteria for OUD.[1]

The intention of the *Safe Prescribing for Opioid Use Disorder* standard of practice is to provide regulated members with clear guidance that allows for safe and responsible management of OUD with evidence-based, full opioid agonist treatments. The standard is deliberately nonprescriptive in the use of specific treatment guidelines, as the treatment modalities for OUD are changing rapidly. We expect regulated members to provide care based on current legislation, guidelines and recommendations, and evidence-based best practices (see Appendix A). Opioid Agonist Treatments (OAT) are described in the medication list provided (see Appendix B).

Effective Oct. 5, 2022, the Government of Alberta introduced new requirements for narcotic transition services (NTS) through an amendment to the *Mental Health Services Protection Regulation* (Regulation). The amendment prohibits the use of full agonist opioid drugs, (e.g., hydromorphone, fentanyl and diacetylmorphine) - except for methadone and slow-release oral morphine for the management of OUD - outside of NTS facilities. Alberta Health Services (AHS) is the only service provider licensed by Alberta Health to provide NTS in the province. Regulated members are responsible for informing themselves and complying with the legislative requirements that apply to their practice. Please find more information below under Legislative changes impacting OUD treatment.

The current guidelines strongly recommend buprenorphine/naloxone and methadone as the first-line treatments for OUD. The advantages of buprenorphine/naloxone are well-recognized and include a superior safety profile, greater flexibility and patient autonomy (which allows for earlier take-home dosing), and unobserved home inductions where

[1] DSM-5 Clinical Diagnostic Criteria for Opioid Use Disorder

appropriate. Consequently, buprenorphine/naloxone can be safely provided with access to laboratory services and a collaborative relationship with a community pharmacist.

In addition to buprenorphine/naloxone, buprenorphine subcutaneous injection (Sublocade®) and buprenorphine subdermal implant (Probuphine®) have recently become available in Canada for OUD treatment.

All buprenorphine OAT products are Tracked Prescription Program (TPP) Type 2 medications, so there is no special prescribing or TPP registration requirements for Sublocade, Probuphine and Buprenorphine/naloxone.

CPSA does not require regulated members to have OAT Approval to prescribe buprenorphine OAT products. The expectation is that regulated members obtain the required knowledge and skills to diagnose OUD and provide front-line treatment and medication following the current guidelines and best practice information, as they would for any other chronic medical condition and medication. For the purpose of the standard and this Advice document, buprenorphine, with or without naloxone, is excluded.

Regulated members **must not** refuse to accept patients from an initiating prescriber based on access to services. There is no difference in how services would be accessed to support other areas of practice, and the access can be indirect: the lab and pharmacy services do not need to be co-located with the regulated member or each other.

## Providing safe and compassionate care

Evidence-informed, comprehensive treatment is known to improve the lives of patients in pain and living with OUD. These patients need patient-centred, holistic care delivered with compassion and support.

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed. Patients with OUD, as those living with any other chronic or relapsing illness, benefit most when engaged as partners in their care along with their healthcare provider. Actions that undermine such a relationship are not only problematic for obvious reasons but can also put a patient at serious risks in the context of a contaminated drug supply. For complex patients or where the diagnosis of an OUD is challenging, a consultation with an

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed.

experienced OAT provider is strongly recommended (see Appendix C). For patients with severe OUD who have not been able to initiate or stabilize on conventional OAT, efforts should be made for timely referral and transitions to a licensed NTS facility in compliance with legislation. Please see Legislative changes impacting OUD treatment below.

Patients with OUD may benefit from harm-reduction interventions, including education about:

- sterile syringe use and safer injection practices to reduce the risk of blood-borne (HIV, hepatitis C) and soft tissue infections;
- access to take-home naloxone; and
- syringe distribution programs and supervised consumption services to reduce the risk of blood-borne infection and fatal overdose (particularly amongst high-risk patients or patients with ongoing opioid use).

Stigma is a major barrier to seeking treatment and maintaining recovery, and respectfully treating people who use substances improves health outcomes and helps save lives. All efforts should be taken to reduce stigma, which contributes to isolation and means patients are less likely to access services. We must all work to change the conversation about OUD. Language matters, so we support and encourage language that puts people first, reflects the medical nature of OUD and promotes recovery.

> *"We must all confront the intangible and often devastating effects of stigma. The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment."* - Patrice A. Harris, MD, MA, Chair: AMA Opioid Task Force

## Education and experience

Knowledgeable and experienced regulated members are an integral part of providing patient-centered care in the treatment of OUD. The ability to choose the most appropriate treatment in complex situations, in the context of rapidly evolving treatment options, requires regulated members have current knowledge and relevant experiential training

and can maintain their knowledge and skills through Continuing Professional Development.

**Regulated members without OAT approval**[2] who wish to provide OAT must complete an approved, preceptor-based course/residency or complete a CPSA-recognized Opioid Dependence Training Program and provide evidence of experiential training, supervision, and mentorship.

To provide readily-accessible education and experiential training options for regulated members, the Alberta Opioid Dependency Virtual Training Program was developed by AHS in collaboration with the Continuing Medical Education Office at Calgary's Cumming School of Medicine. The focus of this program is to give healthcare providers the knowledge, skills and attitudes necessary to provide care to patients with OUD by teaching the complex integration of technical and behavioural competencies required for addiction and mental health in day-to-day clinical practice. AHS also has the Alberta ODT Virtual Training Program available through Provincial Addiction Curricula & Experiential Skills Training (PACES), which can be accessed anytime through their website.

Successful completion of this program meets the educational and experiential training required for approval to initiate OAT for OUD. Upon completion of this course, a certification of completion is sent directly to the regulated member. Regulated members must complete the online application form and provide a copy of the completion certificate to CPSA to obtain an OAT approval. There is no need for regulated members to submit any other evidence.

The program takes a proactive approach—it streamlines the approval process and provides Alberta regulated members with access to the education and training necessary to ensure OAT competency, regardless of location. Regulated members who complete other recognized courses (e.g., BC Center on Substance Use (BCCSU) or Center for Addiction and Mental Health (CAMH)) need to submit the following to obtain approval to initiate OAT for OUD:

[2] Per clause 1 of the *Safe Prescribing for Opioid use Disorder* standard of practice, OAT approval refers to full opioid agonist therapies for opioid use disorder treatment.

- an application for approval;
- evidence of course completion; and
- evidence to support experiential training.

**Regulated members who presently have an OAT approval** (formerly known as a Methadone Exemption/Methadone Approval) for initiating or maintaining treatment for patients with OUD are not required to have any further training to maintain their approval. However, these regulated members are expected to maintain their competence in OAT through ongoing education (as part of their mandatory CPD) and provide evidence of the relevant Continuing Medical Education (CME) upon request.

**Regulated members who temporarily prescribe** OAT for a patient in an inpatient or correctional facility do not require an OAT approval (initiation or maintenance) but must prescribe in accordance with clause (6) of the standard.

When initiating OAT, making dose adjustments or introducing medications that may interact with OAT, it is expected that regulated members providing care in an in-patient or correctional facility setting will consult with the following as soon as reasonably possible:

- the appropriate community prescriber;
- in-hospital addiction services;
- AHS's Referral, Access, Advice, Placement, Information & Destination (RAAPID) service; and
- Alberta's Virtual Opioid Dependency Program (VODP).

Regulated members may proceed without consultation **if** patients require urgent or emergent care. Patients who present for emergency or in hospital care should have access to OAT when it is appropriate in the clinical assessment of the attending healthcare provider.

**Regulated members providing NTS** at licensed AHS facilities will need to meet training and qualification requirements set out in the Regulation and the *Community Protection and*

*Opioid Stewardship Standards* (CPOS Standards). These requirements include training on trauma-informed care, training on how to engage with all patients in a respectful way and cultural competency training. Please see CPOS Standards for more information on required training and qualifications.

## Appropriate settings, continuity and transfer of care

OAT for OUD must be initiated where there is access to Alberta Netcare/PIN data, medical laboratory services and pharmacy services. Regulated members are expected to be able to refer patients to appropriate multidisciplinary support and other resources and services, as indicated by patient preference and suitability to the patient's care. These services do not necessarily need to be located at the same site as the clinic providing OAT for OUD but should be easily accessible for collaboration and continuity of care. Evidence shows that pharmacotherapy should not be offered in isolation, but should include ongoing assessment, monitoring and support for all aspects of physical, emotional, mental and spiritual health. These are equally important components of treating OUD—addressing these needs should be considered the standard of care. Evidence-based psychosocial supports focused on individual circumstances (e.g., housing, employment, etc.) and other survival needs (e.g., social assistance) may also help support recovery from OUD.

OUD treatment with full agonist opioids, except for methadone and any slow, extended, sustained, or controlled-release oral morphine, is restricted to NTS licensed under the *Mental Health Services Protection Regulation.*

### CONTINUITY OF CARE

Continuity of care is also an essential aspect of medical management in all settings. In the absence of the initiating provider, regulated members must have access to other prescribers who can prescribe OAT. It is expected that regulated members working within groups have a process to manage continuity of care and provide coverage for each other. This coverage may be challenging for those who work in rural or remote locations, but regulated members need to be aware of the resources available to help manage this aspect of their practice. Alberta's Virtual Opioid Dependency Program supports regulated members in rural/remote locations in maintaining continuity of care for their patients. The AHS Opioid Use Disorder Telephone Consultation service, a province-wide e-consult service, is another resource for prescribers.

Continuity of care remains a vital part of patient safety, and maintaining prescribers must have firm arrangements to provide patient care in their absence. Collaboration with

colleagues, mentoring networks and educational resources ensures that patient safety is not compromised.

Patients hospitalized, treated in emergency room settings or incarcerated are particularly vulnerable to loss of continuity of care. Regulated members who temporarily provide OAT in these circumstances **must** ensure the patient has a sufficient amount of medication on discharge to allow them to contact their community physician. The community physician must also be notified of their patient's discharge. Direct contact (e.g., by telephone, email) with the community physician is preferred to allow timely communication about the patient's treatment under the temporary prescriber. Written communication should also be provided to the community physician at the time of discharge. Patients without a community provider can be given contact information for the Virtual Opioid Dependency Program (VODP).

Under Section 16 of the Regulation, patients who are hospitalized, treated in emergency room settings or lawfully detained at a designated facility, and are being provided NTS, may continue to receive a designated narcotic drug during their admission. NTSs are to be provided only after consultation or making one's best efforts to consult with the responsible NTS provider. A transitional care treatment plan is developed by the approved hospital or designated facility for discharge to support the patient's resumption of NTS at the licensed NTS facility. The provision of NTS in these settings must comply with Sections 17, 18 and 19 of the Regulations. This **does not** apply to incarcerated patients.

If a change in medication becomes necessary during the patient's hospitalization, emergency room stay or incarceration, a temporary prescriber without active CPSA approval to initiate OAT **must** consult with the initiating prescriber or a qualified colleague to ensure any changes are made appropriately and safely. All initiating prescribers are expected to have a process in place that allows for prompt accessibility of themselves or a delegate prescriber. In urgent or emergent situations, the temporary prescriber must use evidence-based practices to inform their clinical decision.

Collaboration between prescribers during transitions of care is essential to providing continuity and safe patient care.

### TRANSFER OF CARE

The primary care provider can maintain stable patients in a community setting. Transfer of care to a community healthcare provider requires the initiating prescriber to provide the maintaining healthcare provider with a letter of support (sample letter) and an

information checklist. The letter of support should indicate that the initiating prescriber (or appropriate delegate) can be available to provide support, accessibility and advice to the maintaining healthcare provider. The information checklist should provide the maintaining prescriber with information about potential risks from the OAT, possible adverse effects and red flags that may indicate a loss of stability requiring further consultation with the initiating prescriber (or their delegate).

The success of transferring the care of stable patients to community healthcare providers is dependent on the ability of the initiating prescriber to provide accessible support for the maintaining healthcare provider so that patient care is provided safely. Establishing and maintaining a collaborative environment between healthcare providers is integral to this success.

Community regulated members are expected to accept the transfer of care to maintain OAT prescribing (methadone, buprenorphine, slow-release oral morphine) for stable patients and provide patient-centered, holistic care to patients with OUD. Evidence demonstrates that patients receiving team-based health care have improved outcomes, more patient satisfaction and reduced use of hospital, emergency room and specialty clinic services. This treatment also has the advantage of integrating addiction, medical and psychiatric services into mainstream services, reducing the stigma of addiction and the professional isolation of medical staff. Patients may prefer to receive treatment for their OUD in specialty clinics, so supporting patients as they integrate into a team-based healthcare setting is necessary.

Approval to maintain a patient on OAT for OUD is provided to the maintaining physician upon receipt of a support letter from the initiating prescriber. After accepting a patient transfer from the initiating physician, the maintaining prescriber must complete modules 5 and 8 of the Alberta ODT Virtual Training Program. This online program is free and can be used for CME credits. The program also streamlines the approval process by providing the CPSA with confirmation of completion.

Regulated members who have OAT maintenance approval for specific patients (formerly Health Canada methadone exemptions – patient specific) are **not** required to complete further educational training to maintain treatment for present or future patients. However, it is expected that regulated members ensure their competency remains up to date through relevant CME.

When a physician with approval to maintain OAT for OUD accepts the responsibility of maintaining OAT for OUD for additional patients, a letter of support from the initiating prescriber is required for each additional patient.

## Legislative changes impacting OUD treatment

Updates to the *Mental Health Services Protection Regulation*, which went into effect Oct. 5, 2022, restrict the use of full agonist opioid drugs, (e.g., hydromorphone, fentanyl and diacetylmorphine), with the exception of methadone and slow-release oral morphine ), for the treatment of OUD to NTS facilities licensed by the provincial government. The CPOS Standards also came into effect that day.

OAT medications, such as methadone, buprenorphine and slow-release oral morphine, may still be used to treat OUD in community settings (i.e., not AHS-licensed facilities).

Under the Regulation, Alberta Health has established specialized NTSs to manage patients with severe OUD who have not been able to initiate or stabilize on conventional OAT.

- NTS is provided in alignment with the Regulation and the CPOS Standards.
- The intention is to stabilize patients on high-potency opioids, and taper and transition them under expert medical supervision to conventional OAT medications.
- Medication is provided to patients for administration on-site, under the in-person supervision of an authorized regulated health professional. There are no take-home medications provided as part of this service.
- NTS is available in specified AHS facilities licensed by Alberta Health.
    - Healthcare providers may no longer initiate new patients on high-potency opioids to treat OUD outside of a licensed NTS facility as of Oct. 5, 2022 (Nov. 4, 2022 for existing service providers).
    - All patients receiving high-potency opioids for OUD management must transition to one of the AHS facilities providing NTS in the stipulated timeframes.
    - All patients who are unable to initiate or stabilize on conventional OAT medications must be referred to NTS.

- Subject to certain conditions provided in the Regulations, patients of an NTS may be maintained on in-scope opioid narcotics for treatment at approved hospitals (including emergency departments of approved hospitals) or designated facilities under the *Mental Health Act*).

- Expert support is available to assist in transitioning or referring patients to NTS via the AHS Opioid Use Disorder Telephone Consultation services:
  - North of Red Deer: call RAAPID North at 1-800-282-9911 or 1-780-735-0811
  - South of Red Deer: call RAAPID South at 1-800-661-1700 or 403-944-4488

Regulated members and other primary care providers must ensure that the indication for a high-potency opioid narcotic is clearly indicated on the TPP prescription to assist pharmacists in timely and appropriate dispensing. The indication field on the TPP form can be used for this or, in the context of e-prescribing, provided to the pharmacy through alternate means (e.g., as part of dispensing instructions or comments if there is no designated indication field available). If an indication is not listed, the prescription will not be dispensed.

The Regulations do not prevent regulated members from treating patients with high-potency opioids for other medical conditions, including acute/chronic pain or palliative conditions, whether or not an OUD exists. Additionally, regulated members cannot refuse or discharge patients based solely on medical complexity.

If the purpose or indication of a prescription is to use a high-potency opioid to manage OUD, the patient can only receive these medications in NTS. A 150-day transition period applies to existing service providers (defined as a physician or other primary care provider who provided services to a patient using a high-potency opioid narcotic for the patient's OUD or opioid addiction, from July 1, 2021 to Oct. 4, 2022). All transitions to licensed AHS facilities should be **completed by Mar. 4, 2023**.

## Scenarios

### Combination therapy for an OUD diagnosis

What happens if a patient is on an out-of-scope narcotic (e.g., methadone or suboxone) plus an in-scope narcotic (e.g., fentanyl or hydromorphone in any form)?

**Alberta Health response:**

- NTS treat OUD and include the use of one or more designated narcotic drugs, i.e., any full agonist opioid drug except for methadone and slow-release oral morphine (Section 13 of the Regulation).
- As of Mar. 5, 2023, except exemptions granted under Section 16 of the Regulation (approved hospitals, emergency departments of approved hospitals, and designated facilities under the *Mental Health Act*), this patient only has access to in-scope opioid narcotics through a licensed NTS provider.

- Patients can keep receiving conventional OAT medications (buprenorphine, methadone, or slow-release oral morphine) regardless of whether they transfer to a licensed NTS provider.

- **Note:** a patient receiving fentanyl for OUD can only continue receiving this drug after approval of the medical director of NTS and subject to any requirements directed by the medical director (the Government Regulation and Standards associated with it set out specific requirements for fentanyl). Fentanyl patches will not be available.

If the patient is stable, can the primary prescriber continue prescribing all opioids?

- No, not unless the provision of services that use the in-scope narcotics happens in the context of a licensed NTS provider and is in full compliance to the Regulation and CPOS Standards.

## Overlapping OUD and chronic pain

It is not an uncommon clinical situation for both OUD and chronic pain to co-exist. It is also possible that the diagnosis of OUD is unclear, unknown or suspected. In these situations, can a physician outside of NTS offer opioid therapy to the patient (e.g., for treatment of pain)?

**Alberta Health response:**

- The Regulation speaks to the purpose or indication for the prescription, not a diagnosis, and does not prevent regulated members from treating patients with in-scope opioid narcotics for other illnesses, including cancer and chronic pain, regardless of whether an OUD diagnosis is known.

- If there is overlapping OUD and chronic pain, a physician outside of NTS can offer in-scope opioids to the patient **only for the chronic pain treatment** and should follow existing clinical practice guidelines regarding safe prescribing in this situation.

- The patient can receive in-scope opioid narcotics for their OUD only through NTS.

### Imminent risk or overdose

Patients may be at imminent risk of overdose (e.g., known to be actively using illicit supply) and not willing or able to transition to NTS within a reasonable timeframe or similar scenarios where there may be competing risks or potential ethical dilemmas.
Can regulated members outside NTS provide care (e.g., with documentation and additional notification requirements) in this case?

**Alberta Health response:**

- The use of buprenorphine, methadone and slow-release oral morphine is effective at stabilizing patients in the vast majority of cases.

- Primary care providers can reach out to AHS for expert advice in supporting these clients via the AHS Opioid Use Disorder Telephone Consultation services.

- Patients at imminent risk of overdose should be transitioned to a therapeutic dose of conventional OAT under the care of a physician as soon as possible. If their drug use is so severe they are unable to stabilize on a therapeutic dose of conventional OAT, they are an ideal candidate for NTS.

- If their physician has already been providing in-scope narcotics (as an existing service provider), these drugs can be used in combination with conventional OAT to facilitate earlier stabilization. The patient should then be transitioned to a NTS clinic by Mar. 4, 2023. Efforts should be made to protect against diversion by witnessing dosing.

- If regulated members have been sending at-risk patients home with high-potency opioid narcotics in the hope that they'll use them instead of street drugs, the patient's risk of overdose is not often lessened, and diversion is probable.

- Supervised consumption services remain an appropriate venue to protect people from overdose who are unwilling to seek treatment. All patients should be encouraged to

download and use the DORS app if they ever use alone.

- Note that NTS does not include the use of in-scope opioid narcotics if medically indicated for the purpose of stabilizing a patient suffering from opioid withdrawal during the patient's admission to an approved hospital for other indications (Section 13 (c), Regulation).

### Active, untreated OUD requiring care for an acute pain condition

A patient has an opioid addiction (e.g., confirmed street use), but comes in with an acute pain-causing injury.

**Alberta Health response:**

- In-scope opioid narcotics can be provided to patients with an acute pain-causing injury *for the treatment of that pain* outside of a licensed NTS facility.

### Stable patients in a recognized community program

Are stable OAT patients affiliated with community OAT clinics (e.g., Radius Medical (formerly Boyle McCauley), CUPS, Alex Clinic, etc.) required to transition to NTS? What about patients being actively stabilized (e.g., on combination therapy in the process of bridging to an out-of-scope narcotic in the community setting)?

**Alberta Health response:**

- Patients with OUD who are affiliated with an existing service provider and receiving in-scope opioid narcotics for their OUD must transition to NTS by Mar. 4, 2023 to keep receiving these medications.

- Patients being actively stabilized and in the process of bridging to an out-of-scope opioid narcotic in a community setting must be transitioned to NTS by Mar. 4, 2023 to continue receiving in-scope opioid narcotics.

- Primary care providers can reach out to AHS for expert advice in supporting these clients via the AHS Opioid Use Disorder Telephone Consultation services.

## Patient where NTS may not be an option

For patients who are unwilling or not consenting, ineligible for NTS or physically unable to meet the requirements for NTS due to personal mobility, lack of service availability or other challenges, can the primary care physician prescribe in-scope opioids to the patient in this scenario? What options and advice could a physician give to the patient or CPSA to community regulated members?

**Alberta Health response:**

- No, the primary care physician who is an existing service provider cannot prescribe in-scope opioid narcotics to the patient as of Mar. 4, 2023.
- These patients can be supported in transitioning to a therapeutic dose of other opioids, such as buprenorphine, methadone and slow-release oral morphine.
- Primary care providers can reach out to AHS for expert advice in supporting these clients via the AHS Opioid Use Disorder Telephone Consultation services.
- To support implementation of the regulation and ensure availability of NTS, AHS is making NTS available in at least one city in each zone across the province.

It is recommended regulated members do everything possible to educate patients, to reduce risk as much as possible:

- Inform patients of the need to transfer to a NTS provider (if required) and ensure the conversation is documented in the patient's file.
- Inform the patient of the risks of stopping OAT abruptly and document.

All regulated members who manage patients with OUD by prescribing high-potency opioids are encouraged to review the *Mental Health Services Protection Regulation*, the *Community Protection and Opioid Stewardship Standards,* and the Alberta Health Narcotic Transition Service fact sheet for further details.

## Conclusion

A stepped and integrated-care approach, using evidence-based best practices, is an integral part of the safe, effective and sustainable treatment for OUD. Creating comprehensive care and treatment plans, based on the most current legislation, guidelines and recommendations available, can help improve the lives of patients who are in pain and living with OUD.

## Questions?

CPSA team members are here to help. For more information, please email AIR@cpsa.ab.ca.

Regulated members may also consider contacting the Canadian Medical Protective Association (CMPA) if situations arise outside of the above scenarios, for legal advice or for assistance interpreting the legislative requirements.

## Educational and training resources

CPSA Physician Prescribing Practices

Provincial Addiction Curricula & Experiential Skills Training (PACES)

ODT Virtual Health Training Program

Alberta Virtual Opioid Dependency Program

CAMH – Opioid Dependence Treatment Core Course

British Columbia Center for Substance Use

Reducing Stigma Resources

Naloxone Kits – where to access

Supervised Consumption Services

Safe Needle Disposal/Needle Exchange Programs – Streetworks, Turning Point Society, Safeworks

| Review Date | Revision/Change |
|---|---|
| Apr. 2024 | OAT renewal removed: no longer required |
| Apr. 2023 | Section added for temporary OAT prescribing |
| Feb. 2023 | Narcotic transition service requirements added; product availability updated |
| Oct. 2022 | Contact email address updated |
| Nov. 2021 | Links to AB VODT training program added; wording updated |

## Appendix A: Current guidelines for the management of OUD

Best Practices across the Continuum for the Treatment of Opioid Use Disorder

British Columbia Center for Substance Use – OUD Guidelines

CRISM National Guidelines for the Clinical Management of OUD

American Society of Addiction Medicine – National Guidelines for the use of Medication in the treatment of addiction involving opioid use

Canadian Opioid Use Guidelines (CAMH 2021)

## Appendix B: Medications Included in the Treatment of OUD

- Buprenorphine
- Methadone
- Slow-release oral morphine

## Appendix C: Specialty Clinics and Consult Resources

**Virtual Opioid Dependency Program (AHS)**
*Opioid Agonist Therapy, Emergency Medication Treatment & Transition Support*
Phone: 1-844-383-7688
Fax: 403-783-7610

**Opioid Use Disorder – AHS Telephone Consult**
This telephone consult service is for primary care regulated members and prescribers seeking advice regarding:

- Initiating and managing opioid agonist therapy
- Prescribing drugs like buprenorphine/naloxone, methadone or naloxone
- Treating patients with existing opioid use disorder

- Managing opioid withdrawal and consideration of opioid agonist therapy

This service will not provide advice on pain management using opioids or alternatives. Primary care providers who want to consult a pain management specialist may benefit from resources listed by the Calgary Pain Management Centre.

For patients **north** of Red Deer, access the service by calling RAAPID North at 1-800-282-9911 or 1-780-735-0811.

For patients **south** of Red Deer, call RAAPID South at 1-800-661-1700 or 403-944-4488.

**Addiction and Mental Health – Opioid Dependency Program**

Alberta Health Services' Opioid Dependency Program (ODP) clinics are available in Edmonton, Calgary, Fort McMurray, Cardston, Grande Prairie, High Prairie and through the Rural ODP clinic, which serves patients from 60 central Alberta communities.

**What is an eReferral advice request?**

An eReferral advice request is a secure and efficient process within Alberta Netcare, for physician-to-physician advice. *Addiction, Medicine & Mental Health – Opioid Agonist Therapy* joined eReferral in February 2018.

If you have a non-urgent question, are seeking guidance with the management of a patient's opioid use disorder, or are wondering if a referral is appropriate, send an advice request. The response target is five calendar days.