New Brunswick College of Pharmacists
Ordre des pharmaciens du Nouveau-Brunswick

OPIOID AGONIST TREATMENT PRACTICE TEMPLATES

Companion document to the Opioid Agonist Treatment Practice Directive (Policy GM-PP-OAT-01)

The following are suggested formats of Patient, Process and Quality Management Program (QMP) forms. These are meant to be adapted by you for your practice site or you may prefer to create your own. Documentation must be complete and meet requirements according to the Opioid Agonist Treatment Practice Directive (OAT) published in 2022.

Disclaimer: Subsequent practice may require these sample templates be further adapted, however the College will not be maintaining this document. You are encouraged to refer to the OAT, necessary resources and adapt practice tools as appropriate for your practice site.

Patient Focused

1. Pharmacist – Patient Agreement (Methadone)
2. Pharmacist – Patient Agreement (Buprenorphine / Naloxone)
3. Pharmacist – Patient Agreement (Slow-Release Oral Morphine)
4. Take-Home Dose Agreement (Methadone)
5. Take-Home Agreement (Buprenorphine / Naloxone)
6. Administration Log - Methadone
7. Administration Log - Buprenorphine/ Naloxone
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9. Interprofessional Communication DAP Form
10. Prescription Clarification Request Form
11. Communication Fax – Pharmacy to Pharmacy
12. Community Partnership Contact List

Process Focused

1. Prescription for Methadone Template and Examples
2. Take-Home Dose Label Examples
3. Methadone Preparation Log
4. Methadone Preparation Log – Large Volume
5. Methadone Losses / Spills Documentation

QMP

1. Appropriate Action for Administration Errors
2. Pharmacy Team Member Education
3. Calibration of Dispensette
4. Daily Calibration of MethaMeasure

Resources Cross-Reference

This Practice Directive sets minimum standards of the pharmacy team with respect to opioid agonist maintenance treatment. Additional details regarding aspects of OAT referenced in this Directive, including pharmacology and therapeutics, criteria for take-home doses and dosing information are found in the resources listed below.

Information	CAMH Opioid Agonist Maintenance Treatment, 3rd ed. [1]	Other
Breastfeeding	Section 7	
Dosing (Methadone)	Section 7	Reference 3; Appendix 1
Dosing (SROM)		Reference 3; Appendix 3
Dosing (buprenorphine/naloxone)	Section 7	Reference 3; Appendix 2
Ending Treatment	Appendix 10	
Hospitalization	Section 9	
Incarceration	Section 9	
Induction (buprenorphine/naloxone)	Section 7 and Appendix 14 (COWS)	Reference 3; Appendix 2 and Appendix 6 & 7
Injectable OAT (hydromorphone)		Reference 2 & Reference 4
Interactions	Section 2 and Appendix 2	
Lost or stolen doses	Section 6 (p. 58 optional)	
Missed doses	Section 7	
Overdose	Section 2	Reference 3; p23, p32, Appendix 1 and Appendix 2
Pain (treatment of)	Section 8	
Pharmacology/Pharmacokinetics	Section 2	
Pregnancy	Section 7	
Special Populations (Geriatric, adolescent)	Section 7	
Take-home Criteria		Reference 3; Appendix 4
Tapering doses	Section 7 and Table 7.1 and Table 7.4	
Toxicity	Section 2	
Vomited dose	Table 7.1 and 7.4	
Withdrawal	Appendix 3	

1. "Opioid Agonist Maintenance Treatment: a pharmacist's guide to methadone and buprenorphine for opioid use disorder" (CAMH, Third Edition, 2015, by P. Isaac, et al)
2. http://library.bcpharmacists.org/6_Resources/6-2_PPP/1049-PPP67_Policy_Guide_iOAT.pdf

3. http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf
4. https://www.bccsu.ca/wp-content/uploads/2021/07/BC_iOAT_Guideline.pdf

TEMPLATE

Pharmacist – Patient Agreement (Methadone)

Client Name: _____

Date: _____

Renewal Date: _____

Pharmacist-Patient Agreement (Methadone)

Name: _____ Address: _____

Tel #: _____ Postal Code: _____

Date of Birth: _____Prescriber: _____

OUR COMMITMENT TO YOU: *As your pharmacists, we believe in the principles of the methadone maintenance treatment program, and the valuable role it can play in improving people's lives and health.*

To help you succeed in the program we make the following promises:

We will treat you professionally and respectfully at all times. We are part of your health care team and will communicate with your other health care providers when necessary. The kinds of issues we may discuss with your methadone prescriber include:

- missing one or more doses,
- refusal to drink the full prescribed dose of methadone,
- being intoxicated or sedated when you arrive at the pharmacy,
- doses for replacement of lost, stolen or vomited methadone, and;
- visiting another prescriber and being prescribed interacting medications by another prescriber.

We will provide methadone to you exactly as your prescriber has ordered it. We are not able to give you extra doses, early doses, or methadone to take home, unless prescribed. For your safety, we will ensure your identity; this may mean keeping your photo on file, providing us with a picture ID, or the use of fingerprint technology before administration of methadone.

We are required to watch you drink your dose of methadone and have a conversation with you afterward. You may also be required to drink water after swallowing your dose. A private area or a semi-private area is available to you while you are observed taking your medication; please tell us which area you prefer to use.

In order to be able to reach you with important information, we will often question you about your current contact information. This is necessary because during weather events, electrical failure, or natural or man-made disasters, we need to contact you with information about how to access your medication. **In an emergency**, if you cannot be reached via the preferred contact information, **the pharmacy team will use all available options to reach you**.

YOUR COMMITMENT TO US:
I will not arrive at the pharmacy before the pharmacy is open. I will arrive for my daily dose between the hours of _____ and _____ daily (preferably in the morning and should be a consistent time each day). I recognize that I must spread the time between methadone doses by at least 16 hours.

I will always inform the pharmacy team when my contact information has changed; I understand this is vital information for the pharmacist to have, since it is used to contact me in the event of an emergency. If, in an emergency, I cannot be reached via my preferred contact information, the team will use all available options to reach me.

I will respect the pharmacy's neighbourhood. I will ensure that all pharmacy packaging materials and litter are disposed of in the garbage containers provided. I will be respectful of others, including staff, other clients, and neighbours of the pharmacy. I will not abuse any staff member, verbally or otherwise.

If I am prescribed take-home doses of methadone (carries), I will store them safely and securely in my home and will always have my lockbox and key with me. I will not stockpile my methadone doses. I will ensure that all caps on carries are tightly secured and that the doses are kept in a secure place away from others, especially children.

I will confirm I have received the appropriate number of supervised and carry doses (if applicable) and sign for same. I realize that I may be asked to present identification with my picture on it, before receiving methadone from the pharmacy.

I realize I may not be given a methadone prescription if I am under the influence of other substances. I realize any drug misuse will be reported to the methadone prescriber. I will not participate in any illegal activity at the clinic/office/pharmacy etc. I may periodically be expected to present remaining take-home bottles (audit) to the pharmacy.

I realize that my doctor, pharmacist, nurse and other health professionals directly involved in my care may openly communicate with each other concerning any aspect of the methadone program. The pharmacist may obtain information about my medication use from my provincial health care record.

If I see a prescriber other than the methadone prescriber, I will inform them that I am in the methadone program. I agree to undergo supervised urine samples on a periodic basis, as may be required of my program.

I will be observed swallowing my methadone dose and this will be confirmed by speaking to the pharmacist after swallowing the dose and/or drinking water. I will dispose of the container used to drink my methadone dose in the pharmacy.

I realize that all doses must be made up in Tang, unless another comparable liquid is specified by the prescriber on each prescription. Further dilution with water only is not allowed. I will inform the pharmacist if the colour or taste of my dose is different than usual.

I realize I require a valid prescription and no methadone will be dispensed without one. It is my responsibility to make sure the prescription does not expire before a new prescription is presented to the pharmacy. I realize that any doses vomited, or any carries lost will not be replaced without a written prescription from my authorized methadone prescriber.

I realize that a missed day means a missed dose which will not be made up. If I am required to pay for my methadone, I will pay at the time I receive the dose. Failure to pay for my doses may result in discharge from the program.

I have read the above agreement and understand and agree with its content. I understand that failure to honour this agreement may result in my no longer being serviced at this pharmacy.

Client Name: _____ Client Signature: _____

Pharmacist Name: _____ Pharmacist Signature: _____

Date: _____ Renewal Date: _____

TEMPLATE

Pharmacist – Patient Agreement (Buprenorphine/naloxone)

Client Name: _____

Date: _____

Renewal Date: _____

Pharmacist-Patient Agreement (Buprenorphine/naloxone)

Name: _____ Address: _____

Tel #: _____ Postal Code: _____

Date of Birth: _____Prescriber: _____

OUR COMMITMENT TO YOU: *As your pharmacists, we believe in the principles of the buprenorphine/naloxone maintenance treatment program, and the valuable role it can play in improving people's lives and health.*

To help you succeed in the program we make the following promises:

We will treat you professionally and respectfully at all times. We are part of your health care team and will communicate with your other health care providers when necessary. The kinds of issues we may discuss with your buprenorphine/naloxone prescriber include:

- missing one or more doses,
- refusal to take the full prescribed dose of buprenorphine/naloxone,
- being intoxicated or sedated when you arrive at the pharmacy,
- doses for replacement of lost or stolen buprenorphine/naloxone, and;
- seeing another prescriber and being prescribed interacting medications by another prescriber.

We will provide buprenorphine/naloxone to you exactly as your prescriber has ordered it. We are not able to give you extra doses, early doses, or take-home doses, unless prescribed.

For your safety, we will ensure your identity; this may mean keeping your photo on file, or you providing us with a picture ID before administration of your medication.

We are required to watch you dissolve your medication in your mouth and have a conversation with you afterward. While the dose does not have to be fully dissolved, it must be at least reduced to a soft mass. A private area or a semi-private area is available to you while you are observed taking your medication; please tell us which area you prefer to use.

In order to be able to reach you with important information, we will often question you about your current contact information. This is necessary because during weather events, electrical failure, or natural or man-made disasters, we need to contact you with information about how to access your medication. **In an emergency**, if you cannot be reached via the preferred contact information, **the pharmacy team will use all available options to reach you**.

YOUR COMMITMENT TO US:

I will not arrive at the pharmacy before the pharmacy is open. I will arrive for my daily dose between the hours of _____ and _____ daily (preferably in the morning and should be a consistent time each day).

I will always inform the pharmacist when my contact information has changed; I understand this is vital information for the pharmacist to have, since it is used to contact me in the event of an emergency. If, in an

emergency, I cannot be reached via my preferred contact information, the team will use all available options to reach me.

I will respect the pharmacy's neighbourhood. I will ensure that all pharmacy packaging materials and litter are disposed of in the garbage containers provided. I will be respectful of others, including staff, other patients, and neighbours of the pharmacy. I will not abuse any staff member, verbally or otherwise.

If I am prescribed take-home doses of buprenorphine/naloxone (carries), I will store them safely and securely in my home. I will not stockpile my buprenorphine/naloxone doses. I will ensure that the doses are kept in a secure place away from others, especially children.

I will confirm I have received the appropriate number of supervised and take-home doses (if applicable) and sign for same. I realize that I may be asked to present identification with my picture on it, before receiving my dose of buprenorphine/naloxone from the pharmacy.

I realize I may not be given a buprenorphine/naloxone dose if I am under the influence of other substances. I realize any drug abuse will be reported to my prescriber. I will not participate in any illegal activity at the clinic/office/pharmacy etc.

I realize that my doctor, pharmacist, nurse and other health professionals directly involved in my care may openly communicate with each other concerning any aspect of the program. The pharmacist may obtain information about my medication use from my provincial health care record. If I see a prescriber other than the buprenorphine/naloxone prescriber, I will inform them that I am in the program. I agree to undergo supervised urine samples on a periodic basis, as may be required of my program.

I will be observed dissolving my buprenorphine/naloxone dose and this will be confirmed by speaking to the pharmacist and/or demonstrating the tablet(s) are no longer solid. I will dispose of the container used to hold my buprenorphine/naloxone dose in the pharmacy.

I may periodically be expected to present remaining take-home doses to the pharmacy. I realize I require a valid prescription and no buprenorphine/naloxone will be dispensed without one. It is my responsibility to make sure the prescription does not expire before a new prescription is presented to the pharmacy.

I realize that any lost take home doses will not be replaced without a written prescription from my prescriber. I realize that a missed day means a missed dose which will not be made up.

If I am required to pay for my buprenorphine/naloxone, I will pay at the time I receive the dose. Failure to pay for my doses may result in discharge from the program.

I have read the above agreement and understand and agree with its content. I understand that failure to honour this agreement may result in my no longer being serviced at this pharmacy.

Patient Name: _____ Patient Signature: _____

Pharmacist Name: _____ Pharmacist Signature: _____

Date: _____ Renewal Date: _____

TEMPLATE

Pharmacist – Patient Agreement (Slow Release Oral Morphine)

Client Name: _____

Date: _____

Renewal Date: _____

Pharmacist-Patient Agreement (Slow Release Oral Morphine)

Name: _____ Address: _____

Tel #: _____ Postal Code: _____

Date of Birth: _____Prescriber: _____

OUR COMMITMENT TO YOU: *As your pharmacists, we believe in the principles of the Slow-Release Oral Morphine (SROM) maintenance treatment program, and the valuable role it can play in improving people's lives and health.*

To help you succeed in the program we make the following promises:

We will treat you professionally and respectfully at all times.

We are part of your health care team and will communicate with your other health care providers when necessary. The kinds of issues we may discuss with your SROM prescriber include:

- missing one or more doses,
- refusal to take the full prescribed dose of SROM,
- being intoxicated or sedated when you arrive at the pharmacy,
- doses for replacement of lost or stolen SROM, and;
- seeing another prescriber and being prescribed interacting medications by another prescriber.

We will provide SROM to you exactly as your prescriber has ordered it. We are not able to give you extra doses or early doses, unless prescribed. For your safety, we will ensure your identity; this may mean keeping your photo on file, or you are providing us with a picture ID before administration of your medication.

We are required to watch you swallow the beads from the capsule, either by placing them into a soft food such as applesauce or pudding, or by having you put the beads in your mouth and swallow them with water. After that, we will have a brief conversation with you.

A private area or a semi-private area is available to you while you are observed taking your medication; please tell us which area you prefer to use.

In order to be able to reach you with important information, we will often question you about your current contact information. This is necessary because during weather events, electrical failure, or natural or man-made disasters, we need to contact you with information about how to access your medication. **In an emergency**, if you cannot be reached via the preferred contact information, **the pharmacy team will use all available options to reach you**.

YOUR COMMITMENT TO US:

I will not arrive at the pharmacy before the pharmacy is open. I will arrive for my daily dose between the hours of _____ and _____ daily (preferably in the morning and should be a consistent time each day).

I will always inform the pharmacist when my contact information has changed; I understand this is vital information for the pharmacist to have, since it is used to contact me in the event of an emergency. If, in an emergency, I cannot be reached via my preferred contact information, the team will use all available options to reach me.

I will respect the pharmacy's neighbourhood. I will ensure that all pharmacy packaging materials and litter are disposed of in the garbage containers provided. I will be respectful of others, including staff, other clients, and neighbours of the pharmacy. I will not abuse any staff member, verbally or otherwise.

If I am prescribed take-home doses of SROM (carries), I will store them safely and securely in my home. I will not stockpile my morphine doses. I will ensure that the doses are kept in a secure place away from others, especially children.

I will confirm I have received my dose and sign for same. I realize that I may be asked to present identification with my picture on it, before receiving my dose of SROM from the pharmacy.

I realize I may not be given a SROM dose if I am under the influence of other substances. I realize any drug abuse will be reported to my prescriber. I will not participate in any illegal activity at the clinic/office/pharmacy etc.
I realize that my doctor, pharmacist, nurse and other health professionals directly involved in my care may openly communicate with each other concerning any aspect of the program. The pharmacist may obtain information about my medication use from other pharmacies.

If I see a prescriber other than the SROM prescriber, I will inform them that I am in the program. I agree to undergo supervised urine samples on a periodic basis, as may be required of my program.

I will be observed swallowing my SROM dose and this will be confirmed by speaking to the pharmacist and/or demonstrating the beads are no longer in my mouth. I will dispose of the container used to hold my SROM dose in the pharmacy.

I realize I require a valid prescription and no morphine will be dispensed without one. It is my responsibility to make sure the prescription does not expire before a new prescription is presented to the pharmacy.
I realize that any lost take home doses will not be replaced without a written prescription from my prescriber. I realize that a missed day means a missed dose which will not be made up.

If I am required to pay for my SROM, I will pay at the time I receive the dose. Failure to pay for my doses may result in discharge from the program.

I have read the above agreement and understand and agree with its content. I understand that failure to honour this agreement may result in my no longer being serviced at this pharmacy.

Client Name: _____ Client Signature: _____

Pharmacist Name: _____ Pharmacist Signature: _____

Date: _____ Renewal Date: _____

TEMPLATE Take-Home Dose Agreement (Methadone)

TAKE- HOME DOSE AGREEMENT (Methadone)

Methadone is a potent medication. A single dose taken by a person not used to taking methadone or by someone using or abusing other drugs can be fatal. The risk to a child accidentally taking methadone is particularly high.

For this reason, I agree to the following:

1. I will store my take-home doses in a locked box (hard-sided, working lock, not shared with another person or used for another purpose), in a location where it is unlikely to be stolen or accidentally taken by another person. I will show this locked box to my prescriber and/or pharmacist when requested.

2. I have been counselled about appropriate storage. Methadone should be kept refrigerated in a locked box.

3. I will consume my dose(s) on the day(s) they are prescribed only. I will consume my methadone dose in the appropriate manner (a full dose taken once every 24 hours orally).

4. I agree not to give, lend or sell my take-home doses to anyone. I understand that selling methadone is a criminal offence as well as a danger to the community.

5. I agree to return all empty methadone containers on the day I take my next observed dose. I understand I will not receive my next take-home doses if I do not return the empty bottles.

6. Take-home doses are not a right. These are granted by my prescriber in accordance with the clinic policies, and at the discretion of my methadone prescriber.

7. Take-home doses are continued and may be increased so long as I continue to remain clinically stable and able to be responsible for the care of my take-home doses. This is at the discretion of my methadone prescriber.

8. Take-home doses may be cancelled or decreased if I do not remain clinically stable and able to be responsible for the care of my take-home doses.

9. Lost, spilled, vomited or stolen take-home doses may not necessarily be replaced. Lost or stolen take-home doses must be reported to the local police department.

10. I am aware that I can be called in by my prescriber, the pharmacist or clinic staff for a random audit of my take-home doses. When this happens, I will bring my used and unused methadone bottles to the pharmacy or clinic.

11. I will advise the clinic and Pharmacy of any change in my contact information (phone number or address).

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that this will affect my ability to be able to partake in take-home dose program. I have had an opportunity to discuss and review this agreement with my methadone prescriber and/or pharmacist and my questions have been answered to my satisfaction.

Patient Name: _____ Patient Signature: _____

Pharmacist Name : _____Pharmacist Signature: _____

Date: _____ Renewal Date: _____

TEMPLATE
Take-Home Dose Agreement (Buprenorphine/Naloxone)

Take-Home Dose Agreement (Buprenorphine/naloxone)

Buprenorphine/naloxone is a potent medication. A single dose taken by a person not used to taking this type of medication or by someone using or abusing other drugs can be fatal, especially if taken by a child.

For this reason, I agree to the following:

1. I will store my take-home doses in a safe place, out of the reach of children, in a location where it is unlikely to be stolen or accidentally taken by another person.

2. I will consume my dose(s) on the day(s) they are prescribed only. I will consume my buprenorphine/naloxone dose in the appropriate manner.

3. I agree not to give, lend or sell my take-home doses to anyone. I understand that selling a narcotic medication is a criminal offence as well as a danger to the community.

4. Take-home doses are not a right. These are granted by my prescriber in accordance with the clinic policies, and at the discretion of my buprenorphine/naloxone prescriber.

5. Take-home doses are continued and may be increased so long as I continue to remain clinically stable and able to be responsible for the care of my take-home doses. This is at the discretion of my methadone prescriber.

6. Take-home doses may be cancelled or decreased if I do not remain clinically stable and able to be responsible for the care of my take-home doses.

7. Lost or stolen take-home doses may not necessarily be replaced. Lost or stolen take-home doses must be reported to the local police department.

8. I am aware that I can be called in for a random audit of my take-home doses and on this occasion will do so when asked by my buprenorphine/naloxone prescriber, pharmacist or clinic staff.

9. I will advise the clinic and Pharmacy of any change in my contact information (phone number or address).

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that this will affect my ability to be able to partake in take-home dose program. I have had an opportunity to discuss and review this agreement with my buprenorphine/naloxone prescriber and/or pharmacist and my questions have been answered to my satisfaction.

Patient Name _____ Patient Signature _____

Pharmacist Name _____ Pharmacist Signature_____

Date _____ Renewal Date _____

TEMPLATE

Methadone Administration Log

Methadone Administration Log **Month _____ Year _____**

Patient Name:_____ DOB: _____ Payment: _____ Juice: _____

Day	Rx Sequence	Trans-action number	Dose (mg)	Dose (ml)	Lot Number	Expiry Date	Carries Given (#)	Carries Returned (#)	Pay-ment	Time of Day	Patient Assessment confirmation (RPh)	Patient Sign-off
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
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31												

Comments:

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TEMPLATE

Buprenorphine/Naloxone Administration Log

Buprenorphine/Naloxone Administration Log **Month _____ Year _____**

Patient Name:_____ DOB: _____ Payment: _____

Day of the Month	Rx Sequence	Transaction number	Dose (mg/mg)	# of Tablets	Lot Number	Expiry Date	Carries Given (#)	Payment	Time of Day	Pharmacist Observing	Patient Sign-off
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
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31											

Comments:

_____

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TEMPLATE

Slow Release Oral Morphine (SROM) Administration Log

Slow-Release Oral Morphine (SROM) Administration Log **Month _____ Year _____**

Patient Name:_____ DOB: _____ Payment: _____

Day of the Month	Rx Se-quence	Trans-action #	Total Dose (mg)	Capsule Strength	# of Caps Used	Admin Vehicle Used	Lot Num ber	Expiry Date	Pay-ment	Time of Day	Pharmacist Observing	Patient Sign-off
1												
2												
3												
4												
5												
6												
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31												

Comments:

TEMPLATE

Interprofessional Communication using Data/Assessment/Plan (DAP) Note

Interprofessional Communication

Opioid Agonist Treatment

ABC Pharmacy
123 Main Street, Blandville
Phone: 506-555-2111
Fax: 506-555-2112

To: _____

Fax # _____

Regarding: Patient Name _____

Medicare #/ Date of Birth: _____

Today's Date: _____

Date of Occurrence: _____

Data (Subjective and Objective findings):

_____

_____

_____

_____

_____

_____

_____

_____

Assessment:

☐ This patient is at risk of experiencing opioid withdrawal secondary to:

- ____Missed Dose
- ____Partial Dose ingested
- ____Dose vomited
- ____Pharmacist refused to administer
- ____Prescription for OAMT required

- ☐ This patient is at risk of experiencing potentiation of OAMT due to a drug interaction between: _____
- ☐ This patient is at risk of overdose of OAMT (sedation, respiratory depression, ataxia etc.)
- ☐ This patient is at risk of ineffective therapy secondary to:

- ____ Decline in social stability
- ____ Change in health condition
- ____Other:
  _____

Plan:

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacist Name: _____

Response Required: _____ For information only: _____

Pharmacist Signature: _____

Confidential Notice: This facsimile contains confidential, legally privileged information, belonging to the sender. The information is intended only for the use of the individual or entity mentioned above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the content of this facsimile information is strictly prohibited. If you have received this fax in error, please notify us by telephone immediately to arrange for return of the original documents.

TEMPLATE

Opioid Agonist

Treatment (OAT) Prescription Clarification Request

Opioid Agonist Treatment (OAT) Prescription Clarification Request

Date: _____

To (Prescriber): _____ Prescriber Fax: _____

From (Pharmacy): _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Pharmacist Name: _____

Patient Name: _____ Patient Medicare #/DOB: _____

For <u>Prescriber's Signature and Return of form to Pharmacy</u>

We require clarification on the attached prescription.

Please indicate:

- ☐ the actual date the prescription was written
- ☐ dispensing 'start date'
- ☐ dispensing 'stop date'
- ☐ OAMT dose in mg
- ☐ OAMT quantity in tablets / capsules / mg
- ☐ Other: _____

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Appendix B12:

TEMPLATE

Communication Fax – Pharmacy to Pharmacy

Communication Fax – Pharmacy to Pharmacy

Date: _____

Fax to (Pharmacy name): _____

Address: _____

Tel: (506) _____

Fax: (506) _____

This is to confirm that _____ received his/her last drink at our pharmacy on _____ at _____am/pm.

Other Comments: _____

_____

_____

_____

Pharmacist: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number: _____

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(TEMPLATE)

External Agency Contact List

Dental Care

- _____
- _____

Psychological Care

- _____
- _____

Financial Advice

- _____
- _____

Housing (Shelters, Social Development, Co-ops)

- _____
- _____
- Department of Social Development https://www2.gnb.ca/content/gnb/en/departments/social_development/housing.html or
- Public Housing https://www2.gnb.ca/content/gnb/en/services/services_renderer.8615.html

Food Security (Food bank, Community Kitchen, Soup Kitchen)

- _____
- _____
- _____

Resources for women (health and shelters)

- _____
- _____

Clean Needles

- _____
- _____

Youth Drop-In Centers

- _____
- _____

Sexual Health Clinic

- _____
- _____

Wound Clinic

- _____
- _____

Other

- _____
- _____
- _____

Template for a Methadone Prescription

Clinic Name: _____

Fax #: _____

Phone #: _____

Patient Name: _____

Address: _____

Medicare #: _____

Date: _____

Rx: Methadone _____ mg (in words) _____ mg to be taken orally

Dispense _____ mg once daily, mixed in juice (qs to 100ml)

Start Date: _____

Stop Date: _____

Observed dosing in the pharmacy on days circled:

Mon Tues Wed Thur Fri Sat Sun

The following doses are to be dispensed as take home doses:

Mon Tues Wed Thur Fri Sat Sun

Special Instructions: _____

_____ _

_____

Signature: _____ License # _____

Print Name: _____

- If any dose is missed, please notify the prescribe by fax or phone.
- If 3 consecutive doses (or more) are missed, **cancel prescription** and contact the prescriber.

Template for a Buprenorphine/Naloxone Prescription

Clinic Name: _____

Fax #: _____

Phone #: _____

Patient Name:

_____

Address :

_____

Medicare #: _____

Date: _____

Rx: Buprenorphine _____ mg (in words)

_____ mg (with naloxone at 25% of buprenorphine dose)

Dispense _____ mg once daily, to be taken sublingually

Start Date: _____

Stop Date: _____

Observed dosing in the pharmacy on days circled:

Mon Tues Wed Thur Fri Sat Sun

The following doses are to be dispensed as **take-home doses**:

Mon Tues Wed Thur Fri Sat Sun

Special Instructions: _____

_____

_____

Signature: _____ License #: _____

Print Name: _____

- If 3 consecutive doses are missed, please notify the prescribe by fax or phone.
- If 6 consecutive doses (or more) are missed, **cancel prescription** and contact the prescriber.

Acceptable Methadone Take-Home Dose Labels

The Pharmacist's Pharmacy
123 Main Street, Blandville, N.B.
E2A 1B1
506 123 4567

Rx# 1234567 April 25, 20xx

John Smith HLC Dr. Sally Jones
65mg Methadone Compound
DIN 02244290 MFR: Mix Refills: 26
Drink the contents of full bottle (65mg methadone) once daily.
(may add further information here)
Ingestion date: April 26/xx
No refills after May 25/xx
Keep out of reach of children
Methadone may cause serious harm to someone other than the intended patient.
MAY BE FATAL TO A CHILD OR AN ADULT

The Pharmacist's Pharmacy
123 Main Street, Blandville, N.B.
E2A 1B1
506 123 4567

Rx#1234567 April 25, 20xx

John Smith HLC Dr. Sally Jones
65mg Methadone in Juice
DIN 02244290 MFR: Mix Refills: 26
Drink the contents of full bottle (65mg methadone) once daily.
(may add further information here)
Ingestion date: April 26/xx
No refills after May 25/xx
Keep out of reach of children
Methadone may cause serious harm to someone other than the intended patient.
MAY BE FATAL TO A CHILD OR AN ADULT

Methadone Preparation Log

Methadone Preparation Log

Starting volume of stock solution (in ml) _____

Date Prepared	Lot number of stock solution	Expiry Date of stock solution	Patient name or transaction number	Strength per dose (in mg)	Quantity per dose (in ml)	Number of doses prepared	Total quantity of stock solution used (ml)	Quantity of stock solution remaining	Initials of employee preparing doses	Initials of PhC/technician checking

Use the “Quantity of stock solution remaining” column to add new bottles of stock solution entered into inventory. Use the final amount in this same column as the “starting volume of stock solution” on the next sheet.

The calculated quantity of stock solution remaining should be reconciled with each new page and/or when opening a new stock bottle.

Methadone Preparation Log – Large Volume

Methadone Preparation Log Large Volume

Starting volume of stock solution (in ml) _____

Date Prepared	Lot number of stock solution	Expiry Date of stock solution	Strength per dose (in mg)	Quantity per dose (in ml)	Number of doses prepared	Total quantity of stock solution used (ml)	Quantity of stock solution remaining	Initials of employee preparing doses	Initials of PhC/technician checking

Use the “Quantity of stock solution remaining” column to add new bottles of stock solution entered into inventory. Use the final amount in this same column as the “starting volume of stock solution” on the next sheet.

The calculated quantity of stock solution remaining should be reconciled with each new page and/or when opening a new stock bottle.

Methadone Loss or Spillage Log

Special Notes

(OAT Preparation Log may be used to record this information)

Drug (Brand) Name:_______________________________________

Date	Lot Number	Expiry Date	Approximate quantity spilled	Employee #1	Employee #2 (witness)	Total inventory remaining (ml)

Appropriate Action for Administration Errors

If you become aware of a medication dosing error, you must take appropriate and necessary action to minimize harm to the client, ensuring transparency throughout the entire process. This includes prompt consultation with the client's other health care provider(s) for determination of appropriate action. In addition to the following standards specific to methadone, it is expected that pharmacists will manage the error in accordance with the NAPRA *Model Standards of Practice for Canadian Pharmacists* and the individual pharmacy's medication error management policy.

Methadone Under Dose

- Advise the client's physician or MMT clinic and the client as you would with an overdose.
- Once the client is contacted, offer the client the "difference" of methadone between the amount administered and the amount prescribed.
- Should the client refuse to return for the methadone, advise them of the possibility of withdrawal and the symptoms related to opioid withdrawal.
- If the client cannot be reached during business hours, advise them of the error at their next administration. (AADAC, 2007)

Methadone Overdose

As soon as you realize the error:

- Tell the client. If the client has left the pharmacy, contact him or her by telephone. If the client has no phone, you may need to contact the client's physician or MMT clinic to obtain a contact number or send police to the home.
- Advise the client to seek medical attention immediately. If the client refuses medical attention, document the time and details. Ask the client to remain in the care of a friend or relative for the day;
- Advise the client of the symptoms of overdose; including the possibility of euphoria and respiratory depression *(see Signs and symptoms of Opioid Intoxication and Overdose, pg. 35)* Make follow-up contact with the client throughout the day;
- Advise the client's physician or MMT clinic;
- Reassess the client's health condition before administering the next daily dose.

Important Methadone Overdose Information for the Client

- Methadone overdose (receiving a larger dose of methadone than intended) is a serious medical emergency.
- Methadone is a long-acting medication and can stay in your body for many hours.
- Even if you have been on methadone for a long time, taking more methadone than your body is used to can be dangerous. Even what may seem like a small dose increase can be dangerous.
- If you are new to methadone or have not been taking your regular dose, even for a few days, **you are at increased risk of overdose**.
- Taking too much methadone can result in difficulty breathing (slow or shallow breathing), drowsiness, small pupils, and, in some cases, coma and death.
- For this reason, **IT IS ESSENTIAL THAT YOU GO TO THE EMERGENCY DEPARTMENT** to be observed for a minimum of 10 hours, and maybe longer, depending on your symptoms.

- There is treatment available in the emergency department that can reverse the effects that you may get from taking too much methadone. (CPSO, 2005)

Pharmacists who have taken supplementary OAT training:

Name: _____

NBCP Reg #: _____

Course taken: _____

Date completed: _____

Name: _____

NBCP Reg #: _____

Course taken: _____

Date completed: _____

Name: _____

NBCP Reg #: _____

Course taken: _____

Date completed: _____

Name: _____

NBCP Reg #: _____

Course taken: _____

Date completed: _____

Pharmacy Team Members: By signing below, I certify that I have read the NBCP Oral Agonist Treatment (OAT) Practice Directive, that I understand the role I have to play with regard to these patients, and that I will serve these patients based on my role and what the Practice Directive allows me to do.

Name: _____

Position: _____

Date: _____

Name: _____

Position: _____

Date: _____

Name: _____

Position: _____

Date: _____

Name: _____

Position: _____

Date: _____

Name: _____

Position: _____

Date: _____

Name: _____

Position: _____

Date: _____

Template: Calibration of Dispensette Year: _____

Date: _____

Employee: _____ Initial: _____

1ml 5ml 10ml

	Date	Employee Initial	___ml	___ml	___ml
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
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26					
27					
28					
29					
30					
31					

Daily Calibration of MethaMeasure Month_____ Year _____

Employee: _____ Initial: _____

1ml 5ml 10ml

	Employee Initial	1ml	5ml	10ml
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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