PURPOSE

This document details the principles, processes and procedures for both the writing and management of Bay of Plenty Opioid Substitution Service (OST) prescriptions and the dispensing arrangements.

STANDARDS TO BE MET

1. Gazetted / Authorised Prescribing of Medication for Dependence

1.1. The Misuse of Drugs Act 1975 (MODA) outlines both the classification of controlled drugs (Class A, B and C controlled drugs are listed on Schedules 1, 2, and 3 respectively), and the requirements associated with prescribing controlled drugs for dependence. Dependence is defined in MODA as 'in a state of periodic or chronic intoxication, produced by the repeated consumption, smoking, or other use of a controlled drug detrimental to the person in relation to whom the word is used, and involving a compulsive desire to continue consuming, smoking, or otherwise using the drug or a tendency to increase the dose of the drug'.

1.2. Specifically, section 24 of the MODA pertains to the "Treatment of people dependent on controlled drugs". The Director of Mental Health has delegated authority to specify both the service and its designated clinics that may provide treatment with controlled drugs, and the specified medical practitioner ('lead clinician') of BOPAS who may prescribe, administer or supply controlled drugs for the purpose of treatment of people dependent on controlled drugs.

1.3. The 'lead clinician' authorises (See, NZ Practice Guidelines for Opioid Substitution Treatment, 2014, Appendix 13, pg 119) specific named BOPAS medical practitioners to:

a) Prescribe, administer or supply controlled drugs for the treatment of addiction, or
b) Authorise GPs receiving tāngata whai ora / service users from BOPAS (See NZ Practice Guidelines for Opioid Substitution Treatment, Appendix 14, pg 120) on a 3-monthly basis, unless permission has been granted by Medicines Control to provide these on a six-monthly basis
c) Or both.

1.4. Approval of both the service and the medical practitioner (lead clinician), requires certain conditions to be met, including compliance with the National Guidelines 2014, and that the service is committed to a recovery focus. The service is periodically audited against these conditions

2. Principles

2.1. A person authorised to administer or dispense prescribed medication must use the right form of legal prescription and ensure that:

a) the *right* tāngata whai ora / service user receives
b) the *right* dose of
c) the *right* medication, in
d) the *right* formulation, on
e) the *right* script, at
f) the *right* time, and at
g) the *right* place e.g. pharmacy, and consume on premises versus takeaway dose(s)

3. Routine Prescribing and Dispensing

3.1. Who is Involved

a) Preparation of a script may only occur after the medical practitioner's prescribing decision has been documented on a prescribing schedule or electronically in clinical notes.

3.2. Medication prescribed at BOPAS OST

a) Two main opioid replacement medications, methadone and buprenorphine / naloxone are authorised for the treatment of opioid dependence in New Zealand. Collectively they are referred to as Opioid Substitution Treatment or OST.

i. **Methadone**

- is an opioid agonist used in New Zealand for both opioid dependence and pain. Methadone is classified as a Class B Controlled Drug and is listed on Schedule 2, Part 3 (MODA). It therefore needs to be written on a controlled drug script, and for ease of renewal is written for 28 days (although can be written for up to 30 days if necessary). Specifically, methadone for the treatment of opioid dependence is written (by hand or computer generated) on an H572M quadruplicate form and printed on a dot-matrix printer. See Appendix 3 for an example of a completed script and information about the details required.
- BOPAS OST service only prescribe methadone liquid 5mg/mL. This formulation is clear, with no additives. This formulation is the preferred option for the following reasons: (see Appendix 6)
- It is not coloured, hence less likely to be attractive to children.
- If injected, as it has no additional additives, thus it is less likely to cause harm to veins.
- Any exception to this needs to be discussed within the MDT, documented in the tāngata whai ora / service user file, and reviewed annually within the MDT – suitable exceptions might be the use of 2mg/mL in a reducing dose under 20mg.
- Tablets are only prescribed to facilitate travel abroad. They are not suitable for daily use due to difficulty in observing consumption, and difficulty in reducing doses in smaller quantities.

ii. **Buprenorphine**

- is a μ (mu) opioid receptor partial agonist, κ (kappa) opioid receptor antagonist. Its activity reduces craving for opioids and opioid withdrawal symptoms. This minimises the need of the opioid dependent tāngata whai ora / service user for illicit opioid medicines. It is available in two strengths 2 mg buprenorphine / 0.5 mg naloxone and 8 mg buprenorphine / 2 mg naloxone. Currently it is available as tablets only which are crumbled or quartered and administered sublingually (see National Guidelines p.68). It is classified in the MODA as a Class C controlled drug and is listed on Schedule 3, Part 3. (see Appendix 6) The inclusion of naloxone means prescriptions are written on a normal (non-controlled) script form. See Appendix 4 for an example of a completed script.

b) Other opioids at BOPAS OST
   i. In exceptional circumstance where neither methadone nor buprenorphine / naloxone can be tolerated, other opioids such as morphine may be considered after consultation at the multi-disciplinary team meeting (MDT) and with the OST Lead Clinician who would in turn advise the Clinical Director. Morphine has only a 12-hour (approximately) half-life and usually requires twice daily dosing. The rationale for ongoing prescribing of other opioids should be reviewed at least annually within the MDT, and this documented in the tāngata whai ora / service user's notes.

c) Other medication at BOPAS OST
   i. The primary care provider should ideally prescribe all other medication, even for medication initially prescribed by BOPAS OST.
   ii. Staff should be vigilant for adverse effects of OST (see page 101 of National Guidelines 2014), and initiate treatment accordingly as required, e.g. laxatives for constipation. Prescribing should ideally then transition to primary care within a reasonable timeframe.
   iii. Non-opioid drugs of dependence may need to be prescribed by BOPAS OST, in keeping with MODA, e.g. for clinical conditions or to aid oversight of dispensing.

3.3. <u>Routine prescribing: Key points regarding stages of treatment</u>

a) Assessment and Admission and Stabilisation Stage
   i. A comprehensive medical and physical assessment should be done prior to prescribing. Special attention is paid to certain clinical information: intoxication/withdrawal, other drugs or medications, hepatitis status, hepatic and renal function, sequelae of intravenous use and any condition or medication that could impact on QT interval.
   ii. Special populations include pregnant or breast-feeding women, prisoners, youth (<18yo), older adults (>65yo) and those with chronic medical illness or mental illness requiring consideration.
   iii. Both methadone and buprenorphine require 5 half-lives to achieve steady state, roughly 4-5 days for methadone, and 7-10 days for buprenorphine, although reduction of opioid withdrawal symptoms may occur earlier than this.
   iv. Care should be taken with regards overdose and other risks relating to starting OST. The highest risk of overdose occurs during treatment initiation, (and after a period of abstinence e.g. after discharge from prison/rehabilitation/detox (withdrawal) etc).
   v. The starting dose for OST with methadone should generally be in the range of 20-40 mg and not higher than 40 mg; for buprenorphine the dose should be titrated incrementally (often with an initial test dose of 2 – 4 mg). Sedated tāngata whai ora / service users should not receive an initial dose of methadone.
   vi. Doses should be titrated in accordance with tāngata whai ora / service user clinical information, risk formulation, stability, supports and progress.
   vii. A clinical review should occur on day 3 or day 4 to evaluate the initial dose and to plan subsequent dose changes. In unusual circumstances, the dose could be increased earlier than this, and should be done in consultation with the treating medical practitioner.

viii. The dose should not be split during the Assessment and Admission phases.
ix. During Assessment and Admission, and early Stabilisation stages, all doses must be consumed under observation (no takeaway doses) unless exceptional circumstances require alternative arrangements, and these need to be discussed with the MDT and lead medical practitioner or delegate.

b) Ongoing OST Stage and Shared Care
i. Prescribing must take into consideration the tāngata whai ora / service user's presentation, stability, adverse effects of medication, other AOD use, interactions with other prescribed and illicit medication, co-existing medical and mental health issues should be regularly reviewed at the regular medical review.
ii. The dose may be increased (only with medical practitioner approval) in accordance with stability and dependence (e.g. craving, compulsion, other use) and clinical review/oversight. Extra precaution is taken for daily doses of methadone over 120mg. (See 6. Variances in Prescribing below). The maximum daily dose for buprenorphine is 32mg.
iii. Takeaway doses (doses not consumed onsite under observation at the designated pharmacy) may be useful to support recovery as part of the transition to Shared Care with the tāngata whai ora / service user's GP. Indicators of stability need to be taken into account when deciding about takeaway doses. See below, 5. Takeaway Doses.
iv. See below for Variances in Prescribing (split dose, high dose, takeaways >3 days per week).
v. A tāngata whai ora / service user may initiate dose reduction or cessation at any time, allowing reasonable time for script generation and management. Information from any member of the MDT may be useful to help the tāngata whai ora / service user manage a reduction, communicating to the tāngata whai ora / service user the high relapse rate with rapid reductions. Reduction plans should be discussed and planned at the tāngata whai ora / service user's review with their medical practitioner and keyworker.
vi. Tāngata whai ora / service users may elect to transfer from methadone to buprenorphine, or vice versa. This decision needs to be made with the treating medical practitioner and needs to be clinically appropriate.
vii. When transferring from methadone to buprenorphine/naloxone, the micro-dosing method is used. This method does not require the tāngata whai ora / service user to present in withdrawal prior to starting buprenorphine/naloxone, thereby removing barriers to treatment options.

3.4. <u>Routine Dispensing: Key points</u>
a) Doses of medication are specified for either consumption under close observation at a pharmacy or dispensed as a takeaway (consumed away from a pharmacy).
b) Methadone, buprenorphine / naloxone and other medications prescribed by AOTS are dispensed and administered by a community pharmacy.

c) BOPAS OST have a list of pharmacies that have agreements in place to dispense OST to our tāngata whai ora / service users. The Te Whatu Ora Hauora a Toi Bay of Plenty MH&AS Pharmacy team is available to provide support and guidance to community pharmacies as needed.

d) Only Pharmacists and medical practitioners may administer doses.

4. Takeaway Doses

"It is recommended that …opioid substitution medicine be observed to be consumed at the pharmacy or other dispensary on at least three non-consecutive days per week. During the stabilisation phase, takeaway doses can only be authorised for exceptional circumstances. Doses administered via an agent are considered to be takeaway doses. When considering providing takeaway doses, providers should take greater caution when higher doses of methadone (above 120 mg daily) or buprenorphine (above 32 mg daily) or concurrent prescribing of other opioids or benzodiazepines are involved. Restricted dispensing arrangements may be required in these cases." (National Guidelines 2014, page 36)

"Once stabilisation is achieved, individualised goals focus on promoting wellness, tāngata whai ora / service user self-management and community participation within a family/whanau context should assume a high priority."(Deering 2007).

4.1. Principles of Takeaway Provision

a) Takeaway doses support recovery and reflect overall stability in keeping with the plan for the tāngata whai ora / service user's transition to primary care as soon as practicable.

b) Takeaway provision is informed by each tāngata whai ora / service user's clinical presentation, engagement and progress as well as stability and recovery factors.

c) At minimum, the tāngata whai ora / service user must be dose-stable and be actively registered with a GP, before takeaway doses are considered.

d) Takeaways generally occur in Ongoing OST and Shared Care treatment phases, after the Admission and Assessment and Stabilisation stages.

e) Actively tailor takeaways to the tāngata whai ora / service user's needs at any stage (e.g. some Shared Care tāngata whai ora / service users may benefit from more frequent dispensing).

f) Other drug use may prompt an assessment of risk, which could lead to a review of takeaway arrangements

g) Overall recovery and stability is more relevant than duration in treatment.

4.2. Safety Criteria

Safety criteria need to be met for takeaways to be considered:

a) safety for the tāngata whai ora / service user, including consideration of:
   i. tāngata whai ora / service user stability and presentation
   ii. other alcohol and/or other prescribed or non-prescribed drug use
   iii. coexisting medical and mental health conditions
   iv. opioid medication metabolism (e.g. age dependent)

b) safety for children / dependents living with the tāngata whai ora / service user including storage of medication

c) safety for the community including the risks of diversion

d) legal requirements (MODA 1975 and Medicines Act 1981)

4.3. Prerequisites for granting Takeaway doses

See National Guidelines p.36; OST and You p.20

a) Prerequisites for granting takeaway doses might include the following stability measures:
   i. Purpose and benefit of takeaway doses for this particular tāngata whai ora / service user
   ii. Current use of illicit substances/non-OST medications / alcohol, including intravenous and/or risky use
   iii. Physical health and self-care
   iv. Ability to adhere to prescribing regimen
   v. Needs of their significant others (e.g. children)
   vi. Ability to safely store OST
   vii. Engagement with treatment: scheduling and attending appointments and working towards treatment and recovery goals
   viii. Enrolled with a GP
   ix. Social roles (e.g., in housing, employment, parenting, study, social activity)
   x. Relationships with partners, children and other providers
   xi. Management of any co-existing medical and mental health problems
   xii. Criminal activity or legal issues - current

Please note this is not a checklist - tāngata whai ora / service users do not have to achieve every one of the points above to be considered 'stable'.

4.4. Takeaway agreement

a) The tāngata whai ora / service user and service have mutual responsibilities. Before receiving any takeaway doses, a discussion takes place about service expectations between the tāngata whai ora / service user and key worker. Once takeaways have been agreed upon, the tāngata whai ora / service user agrees to and signs the "Responsibility for takeaway doses" form together with the key worker and/or prescriber. This is stored in the tāngata whai ora / service user's file.

4.5. Pathway for implementing takeaway doses

a) When a tāngata whai ora / service user requests takeaways, the tāngata whai ora / service user's key worker or medical practitioner will:
   i. Discuss the role of takeaways with the tāngata whai ora / service user ~~client~~, preferably at the tāngata whai ora / service user's regular face-to-face appointments
   ii. Gather relevant information about the tāngata whai ora / service user's request for takeaway changes
   iii. Consider the potential inconvenience to the tāngata whai ora / service user if the request is declined
   iv. Review the tāngata whai ora / service user's current prescribing regimen.
   v. Review the tāngata whai ora / service user's stability
   vi. Inform the tāngata whai ora / service user of the outcome and provide an explanation if declined
   vii. Discuss the request at MDT

b) Although BOPAS OST takes an individualised, progressive approach to takeaways the usual pathway is as follows:

Stabilisation stage	• Daily observed doses with weekly nurse/case manager follow-ups
	• A single takeaway (e.g. Sundays) once dose is stable and tāngata whai ora / service user is enrolled with a GP
Ongoing OST stage	• With increased stability, another non-consecutive takeaway may be added. • Tāngata whai ora / service user should be suitable for monthly key worker appointments
	• With ongoing stability, active recovery and engagement with the GP, a third and non-consecutive takeaway dose can be added. • Non-consecutive doses are preferred, but exceptions can be made when required and in agreement with the MDT.
	• Further takeaways (up to a max of 4 per week whilst not in GP Shared care) would need MDT agreement, e.g. if: – Observed consumption interferes with occupational / social functioning – The tāngata whai ora / service user is ill and observed consumption or dose delivery are not options – Providing takeaways would reduce harm more than observed doses

5. Variances in Routine Prescribing

Variances in routine prescribing include split doses, high doses and extra takeaway doses.

5.1. Split doses

a) Split doses for Buprenorphine / naloxone is not indicated, however under unusual circumstances, and in agreement with the lead clinician and MDT it can be considered. The rationale should be documented, and reviewed annually.

b) Periodically, methadone split doses are considered, in circumstances discussed below. Split dosing rates are routinely reported to Ministry of Health.

c) Indications include pregnancy, fast metabolism (peak: trough ratio of >2:1 after 4 days observed daily consumption and clinical observation confirming pre-dose withdrawals) and pain disorder (of such a nature that a Pain Specialist / team opinion has been provided) (National Guidelines, 2014).

d) Where one of the split doses is a takeaway, the majority (60% or more) of a split dose must be consumed in the pharmacy (usually in the morning).

e) Initially once split doses are granted the tāngata whai ora / service user might be expected to dose all doses observed in the pharmacy, until such time the usual stability measures around takeaway doses are satisfied.

f) All tāngata whai ora / service users within specialist service on split dosing must consume both their doses observed in the pharmacy at least once a week. This needs to be at least 4 hours apart, and should be indicated as such on the prescription. This is to confirm continued tolerance.

g) For tāngata whai ora / service users in GP Shared care on split doses, the need to be dosing twice in one day once a week, can be reviewed within the MDT on a case by case basis. It is recommended that both doses are observed in the pharmacy at least annually where it is felt this does not need to happen on a weekly basis.

h) Periodically, and as the body's metabolism changes with age, fast metabolism should be reconfirmed by confirming the peak and trough ratio of >2:1.NB. If daily dispensing may compromise tāngata whai ora / service user safety (e.g. potential reduced tolerance due to non-consumption), the tāngata whai ora / service user should be informed of these risks. It is preferable to provide this information in writing to the tāngata whai ora / service user via the pharmacy. Post-dose checks may be necessary.

5.2. <u>High dose</u>

a) Methadone receptor occupancy usually requires between 60mg and 120mg (WHO. 2009. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva: World Health Organization). Some tāngata whai ora / service users require less and some tāngata whai ora / service users require more to manage their opioid dependence, and doses are largely tāngata whai ora / service user-lead. Higher doses of methadone are routinely reported to the Ministry of Health

b) There is no specific maximum methadone dose, but doses over 120mg need careful consideration. Where a tāngata whai ora / service user is prescribed a dose over 120 mg, this needs to be discussed and reviewed within the MDT at least annually. The risks and benefits should be discussed at MDT and an annual ECG is suggested, especially when there are other medications prescribed that could lead to prolonged QTc. The risks of high doses of methadone also need to be highlighted and discuss with the tāngata whai ora / service user at a regular interval, and support provided to gradually reduce, however this needs to be carefully weighed up so as to not risk relapse.

c) Refusal of an ECG by the tāngata whai ora / service user should be discussed by a medical practitioner with the tāngata whai ora / service user regarding the risks associated with dose and QT prolongation, and information should be provided. The tāngata whai ora / service user's capacity to make an informed decision should be documented. Should the tāngata whai ora / service user have capacity, refusal is not enough to warrant involuntary reduction in the face of no other concerning clinical features. If in doubt, discuss with the MDT and lead medical practitioner.

d) Buprenorphine/naloxone has a maximum dose of 32mg daily. This dose should not be exceeded.

e) OST should be titrated according to the management of opioid withdrawal and dependence symptoms, with ongoing craving, misuse and compulsion being frequent indicators. Withdrawal symptoms and/or signs (including pre-dose or peak presentation) help evaluate the efficacy of the current dose.

f) For GP shared care tāngata whai ora / service users, an annual ECG is also recommended when methadone doses over 150mg are prescribed, or lower doses alongside other medications that can prolong QTc.

5.3. More than 3 takeaway doses per week on a regular basis

a) "Less frequent and flexible dispensing can be considered for tāngata whai ora / service users in GP care, tāngata whai ora / service users with employment arrangements that require flexibility and stable tāngata whai ora / service users living in rural areas where there are logistical difficulties in attending a dispensing service." (National Guidelines 2014 p.36)

b) …" Usually tāngata whai ora / service users should have no more than four takeaway doses in hand, although service providers can use their discretion in this regard." (National Guidelines 2014 p.37)

5.4. BOPAS OST tāngata whai ora / service users:

a) Tāngata whai ora / service users are prescribed up to a maximum of 3 takeaway doses per week, not on consecutive days. Tāngata whai ora / service users requiring more than this to fulfil their recovery goals should first be transitioned to Shared Care.

b) In exceptional circumstances for increased takeaways, the team will discuss this at MDT and consult with the prescribing medical practitioner, after a full assessment of the tāngata whai ora / service user's circumstances with verification, where appropriate (e.g. the tāngata whai ora / service user's work commitments and imminent Shared Care transfer).

c) Special conditions such as overseas travel necessitating less than once weekly consumption must be discussed with the prescribing medical practitioner and MDT. Where overseas travel is to a country where OST services are available, preference is for a temporary transfer of treatment to a suitable local facility.

5.5. Shared Care tāngata whai ora / service users:

a) The GP should consult with the OST service before considering prescribing more than 3 takeaways per week. If the OST service agrees to the plan, the service must arrange for an updated Authorisation to Prescribe for the GP and Ministry of Health, reflecting these agreed changes.

b) All OST service tāngata whai ora / service users consuming in New Zealand should consume at the pharmacy at least once weekly.

6. Variances from Routine Dispensing

Variances from routine dispensing include suspended doses and the use of an agent.

6.1. Withheld doses

a) A temporary hold allows for reinstatement of the dose for later the same day. Some possible indications of this are:

i. Tāngata whai ora / service user attendance at an appointment that day, when all other efforts have proven ineffective.

ii. Completion of requested laboratory tests, when all other efforts have proven ineffective, or a random result is required (usually this will be discussed prior in MDT or with the prescribing medical practitioner).

iii. To prevent potential double-dosing (e.g. hospital admission).

b) Attempts are made (and documented in the clinical notes) to communicate any changes to the tāngata whai ora / service user before they happen.

c) Reinstatement of a dose requires:
   i. The task (e.g. appointment, or laboratory test) to be completed. If not, the team involved in the plan (e.g. key worker and/or medical practitioner) should review the plan.
   ii. Advice to the Pharmacist using the appropriate Changes to Dispensing form and follow-up phone call to confirm receipt.
   iii. Advice to the tāngata whai ora / service user, if needed.

6.2. Use of an agent

a) An agent may be considered to collect OST medication in exceptional verified circumstances as an interim measure (e.g. if the tāngata whai ora / service user is significantly debilitated due to ill health).

b) The OST service should be reasonably confident that the authorised agent is responsible and suitable.

c) The agent is usually authorised for a maximum of the tāngata whai ora / service user's usual number of takeaway doses though this can be discretionary.

d) The medical practitioner must authorise the changes to dispensing.

e) If the tāngata whai ora / service user cannot consume at least once weekly, or if the situation is likely to be of longer duration than one prescription, this needs to be discussed within the MDT.

f) Steps required to authorise an agent:

Step	Action	Responsibility
1	The OST medical practitioner signs the *Changes to dispensing* form, agreeing to a specified number of doses to be collected by the designated agent	Doctor
2	On the *Receipt of takeaways on behalf of an OST tāngata whai ora / service user* form, document: – agent's name and address – form of identification the agent will use at the pharmacy – number of doses the agent is authorised to collect – date of collection – days on which the doses are to be used – details regarding how the doses will be stored and administered – cross-reference *Changes to dispensing* form	Key worker
3	Email *Receipt of takeaways on behalf of an OST tāngata whai ora / service user* and *Changes to dispensing* form to the pharmacy	Key worker or clinical support
4	Advise agent about process e.g. storage, administration	Key worker
5	Present identification to the Pharmacist and sign receipt of specified doses, on the *Receipt of takeaways on behalf of an OST tāngata whai ora / service user* form	Agent

Step	Action	Responsibility
6	Email the signed *Receipt of takeaways on behalf of an OST tāngata whai ora / service user* form, to The OST service	Community Pharmacist
7	File the signed form in the tāngata whai ora / service user's file under *Prescribing/Dispensing*.	Key worker or clinical support

7. Changes to existing prescriptions, urgent prescriptions and changes to dispensing

7.1. Principles

a) Changes to prescribing or dispensing may result from tāngata whai ora / service user request, or clinical indication

b) The need for changes should usually be considered at tāngata whai ora / service user review with medical practitioner and keyworker/nurse.

c) Non-urgent requests require at least three working days' notice from the tāngata whai ora / service user.

d) Urgent changes must be discussed with the medical practitioner. Changes outside of standard treatment must be discussed at MDT.

e) Urgent requests must meet criteria for urgency, and includes:
   i. Recommencements following hospitalisation
   ii. BOPAS OST service scripting errors
   iii. Sudden work-related circumstance (as defined individually for each tāngata whai ora / service user and recorded in the clinical notes for reference)
   iv. Unforeseen crises
   v. Pregnancy
   vi. Sudden illness

f) Service responsiveness depends on resource, prioritisation of needs, and suitability of the request

g) The OST service strongly supports measures to prevent missed doses, although this is occasionally inevitable.

h) Changes must be emailed to the relevant pharmacy/pharmacies; a follow-up call to the pharmacy must be made, to confirm receipt.

i) Shared Care changes must be communicated to the prescribing GP by fax, letter or phone call.

j) All clinical staff may withhold or cancel prescriptions in writing where clinically indicated.

k) Service-driven changes are best done in face-to-face consultation with the tāngata whai ora / service user.

l) If face-to-face consultation is not an option for service-driven changes, attempts must be made to inform the tāngata whai ora / service user by phone and/or in writing (e.g. via emailed letter to pharmacy or letter to the tāngata whai ora / service user's home address), outlining the reasons for the interventions.

m) The tāngata whai ora / service user's treatment plan should reflect changes.

7.2. After identifying a need for change(s)

a) The key worker:

i. Takes action at the time of receipt of request, so that all preparation is done in advance.

ii. Where a change happens, but a new script is not required:

- A *Changes to Dispensing form* is required to be emailed to the pharmacy and then the pharmacy is phoned to confirm receipt.

iii. Where a new script is required, the keyworker :

- Discuss prescription request with team/medical practitioner so that the Pharmacist/clinical support/medical practitioner can prepare the prescription.
- Ensures tāngata whai ora / service user photograph is up to date.
- Ensures Takeaway Agreement has been discussed with and consented by the tāngata whai ora / service user.
- Should a new pharmacy be involved, the keyworker:
  - obtains pharmacy agreement to accept a new tāngata whai ora / service user
  - informs tāngata whai ora / service user about pharmacy responsibilities, expectations and consumption procedures (see also OST and You pp.22-24)

iv. Prepares a form to the current and new pharmacy informing them of the following:

- Date of last dose at current pharmacy
- Date of first dose at new pharmacy
- Return date to current pharmacy (if appropriate)
- Current dose of OST prescribed
- Takeaway arrangements if any

b) The medical practitioner:

i. Ensures a team member has documented the discussion regarding any proposed changes.

ii. Signs any new scripts, ensuring 'replacement' identified if the pharmacy (and medication) is still the same.

iii. Ensures changes are reflected on the prescribing record (pink sheet)

8. Special Considerations

8.1. Lost scripts

a)

b) A replacement script is required along with cancellation of any old/existing scripts.

c) The Pharmacist may accept a medical practitioner's verbal order over the phone, with a follow-up script emailed and posted either the same day or the next day (if after business hours).

d) Some urgency is required if the tāngata whai ora / service user is waiting at the pharmacy to be dosed.

e) The replacement script records this as: "Replaces script no. (1234)." Or to state "THIS SCRIPT TO REPLACE ALL PREVIOUS for all other scripts

8.2. Missed doses

See 5.4 National Guidelines

a) Opioid tolerance may be reduced if a tāngata whai ora / service user misses repeated doses of opioid substitution medication. This may increase the risk of overdose when the full dose is reintroduced.

b) Tāngata whai ora / service users may decline prescribed doses at any time but any declined dose is a missed dose

c) Tāngata whai ora / service users who miss three or more consecutive doses need a medical practitioner's involvement to restart dosing.

d) Priority appointments are usually required for these tāngata whai ora / service users (e.g. take an appointment from an existing tāngata whai ora / service user) or discuss options with medical practitioner or clinical lead. Tāngata whai ora / service users who repeatedly seek re-admission need MDT review to discuss options and ideas before being offered another restart.

8.3. Methadone - Process of reintroduction

See National Guidelines 2014 (p.38)

No. of consecutive doses of methadone missed	Recommended Action
1 dose	• Dispense the usual dose unless there are concerns e.g. intoxication
2 doses	• Dispense the usual dose unless there are concerns e.g. intoxication
3 doses	• The medical practitioner or stabilisation nurse (in consultation with medical practitioner) must review the tāngata whai ora / service user before the medical practitioner prescribes or releases a dose. • Unless there is evidence of intoxication, the usual dose can be given. Alternatively, a half dose may be given that day if there has been no other drug use, and the usual dose resumed the next day
4 – 5 days	• The medical practitioner or stabilisation nurse must review the tāngata whai ora / service user for dose stability • including sedation before the medical practitioner prescribes a dose. • The first reintroduction dose should be 50% of the usual daily dose, with the aim of returning to the previous dose within seven days, increasing at a rate of 10 to 20 mg per day until the previous dose is reached.
5+ days	• The medical practitioner must review the tāngata whai ora / service user before the medical practitioner prescribes. Standard induction (Assessment and Admission) should occur

8.4. Buprenorphine/naloxone - Process of reintroduction

No. of consecutive doses of methadone missed	Recommended Action
1 dose	• Dispense the usual dose unless there are concerns e.g. intoxication
2 doses (also Buprenorphine / naloxone alternate day dosing)	• Dispense the usual dose unless there are concerns e.g. intoxication • If the tāngata whai ora / service user is on alternate day Buprenorphine / naloxone dosing, dispense the remainder of the dose for the dosing period if the tāngata whai ora / service user presents by the third day's dose, provided there are no concerns *e.g. a tāngata whai ora / service user who usually consumes 24 mg on Monday, Wednesday and Friday but does not present on Wednesday may be given 12 mg on Thursday, followed by the usual dose on Friday*
3 doses Buprenorphine / naloxone	• The medical practitioner or Stabilisation Nurse must assess the tāngata whai ora / service user before the medical practitioner prescribes or releases a dose. Unless there is evidence of intoxication, the usual dose can be given. • Alternatively, a half dose may be given that day if there has been no other drug use, and the usual dose resumed the next day • Tāngata whai ora / service users who consume alternate day Buprenorphine / naloxone will have missed the equivalent of 5 days dosing
3 days Buprenorphine / naloxone (alternate day dosing)	• The medical practitioner or Stabilisation Nurse, must assess the tāngata whai ora / service user before dosing) the medical practitioner prescribes another dose as the equivalent of 5 days will have been missed. • See '4 - 5 days Buprenorphine / naloxone below
4 – 5 days Buprenorphine / naloxone	• The medical practitioner or Stabilisation Nurse, must assess the tāngata whai ora / service user before the medical practitioner prescribes or releases a dose. • The first reintroduction dose should be 50% of the usual daily dose, with the aim of returning to the previous dose within 3 days, increasing by up to 8 mg per day (Gowing 2013). • The treatment team should review the tāngata whai ora / service user's dosage at this time.
5+ days	• The medical practitioner must assess the tāngata whai ora / service user before the medical practitioner prescribes. • If either buprenorphine or methadone is to be recommenced, standard induction should occur (see 3.2 a) i) starting dose of methadone and 3.2 a) ii) starting dose of Buprenorphine / naloxone).

8.5. Vomited dose

a) Vomiting following Buprenorphine / Naloxone consumption does not require replacement as absorption is sublingual. The OST service will only consider replacing vomited methadone when:
   i. the vomiting occurs within no more than 30 minutes of consumption and was observed by a clinician or the Pharmacist. In this case it will likely only be 50% of the usual dose.
   ii. In a pregnant tāngata whai ora / service user where there is the risk of miscarriage with withdrawal, if vomiting has been reported, discuss with the prescribing medical practitioner. If vomiting occurred within 30 minutes of consumption, consider replacing a dose, or alternatively offer a review of the tāngata whai ora / service user later in the day to assess for onset of withdrawals.

b) In the case of pregnancy if an ongoing problem consider and implement alternative solutions (See National Guidelines page 38).

8.6. Lost, stolen, spilled or leaked OST doses

a) The OST service does not generally replace lost, stolen, spilt or leaked doses.

b) In exceptional circumstances that can be verified (see Guidelines 2014 p. 38) and in consultation with the prescribing medical practitioner and the MDT, the tāngata whai ora / service user may be assessed for withdrawal. If the medical practitioner is satisfied there is sufficient evidence of withdrawal, and a dose is authorised, this must be consumed as observed in the pharmacy.

c) If the Pharmacist spills a dose during the dispensing process, the OST service will not issue a replacement prescription. The Pharmacist should re-dispense the dose to ensure tāngata whai ora / service user is given correct dose, and document it in their Controlled Drug Register as a replacement dose for dose spilled.

d) After-hours replacement of OST doses
   i. The service does not support the replacement of doses after hours, but recommend supportive medication is offered to manage withdrawals until the service can be contacted.
   ii. Shared Care tāngata whai ora / service users: the prescribing GP and the tāngata whai ora / service user's pharmacy must be able to be contacted to verify their situation excepting immediate needs (e.g. the tāngata whai ora / service user presents in obvious withdrawal).
   iii. Note: Any prescribed replacement dose must be consumed under observation

8.7. Pharmacy dispensing errors

a) This refers to a Pharmacist's accidental error such as giving more than the tāngata whai ora / service user's prescribed dose (over- dose) or less than the tāngata whai ora / service user's prescribed dose (under-dose).

b) Over-dose

In any event of an over-dose (e.g. if a Pharmacist informs the OST service that they have administered more than the prescribed OST dose / medication to a tāngata whai ora / service user) the OST service should ensure:

i. The Pharmacist advises the tāngata whai ora / service user of the medication error and if still onsite is asked to remain on the pharmacy premises whilst advice is sought.
ii. If the tāngata whai ora / service user has left the premises the community Pharmacist is advised to make every effort to contact the tāngata whai ora / service user.
iii. The issue is discussed with the key worker, medical practitioner and clinical lead and the need to contact emergency services is assessed.
iv. Use of other substances (e.g. benzodiazepine prescriptions, alcohol) should be assessed.
v. Whether a tāngata whai ora / service user drove (or will be at peak dose at 3-4 hours) is taken into consideration.
vi. Where there are significant concerns for the tāngata whai ora / service user's wellbeing the tāngata whai ora / service user's family support system and / or emergency contact situation should be clarified and contacted if necessary (e.g. the tāngata whai ora / service user should not drive themselves nor remain alone).
vii. Safety takes precedence over privacy.
viii. The tāngata whai ora / service user should be advised of a follow-up plan e.g. to see the key worker / medical practitioner over the next four hours or the need to attend the Emergency Department etc.
ix. The tāngata whai ora / service user is advised to not use other CNS-depressants (e.g. alcohol, benzodiazepines etc).
x. If the tāngata whai ora / service user is unwilling to see the medical practitioner advise the tāngata whai ora / service user to present at hospital for observation.
xi. Stress the need for observation to continue past the peak of 4 hours.
xii. As soon as practicable, an incident report is completed.
xiii. The tāngata whai ora / service user may need to be seen the following day before consuming.
xiv. If considering altering or withholding the following dose, the tāngata whai ora / service user is reviewed face to face.
xv. Discuss the situation with the Lead Clinician if the dose is likely to be withheld.

If the tāngata whai ora / service user has low-dose tolerance of OST (e.g. below 50mg methadone or equivalent) their risk may be considerably higher if given a significant over-dose than a tāngata whai ora / service user who has a higher dose tolerance.

c) Under-dose
In any event of an under-dose (e.g. if the Pharmacist advises the OST service that they have administered less than the usual prescribed OST dose / medication to a tāngata whai ora / service user) BOPAS will:
i. Provide the Pharmacist with the tāngata whai ora / service user's current contact details or will contact the tāngata whai ora / service user on behalf of the pharmacy to advise them on how to receive the rest of their medication (e.g. return to Pharmacy).
ii. Advise the pharmacy not to accept the return of already dispensed medication and arrange for the outstanding amount to be dispensed.
iii. If necessary, arrange an alternate pharmacy to dispense the outstanding amount (e.g. if the tāngata whai ora / service user is unable to return to their usual pharmacy) – a new prescription will be required.
iv. Complete an incident report as soon as practicable.

9. Public Holidays

9.1. Public holiday prescribing is prepared and distributed by using a holiday schedule or documenting the plan on the prescription if indicated.
9.2. The key worker and medical practitioner should liaise regarding tāngata whai ora / service user safety issues and review with the team if indicated.
9.3. Where appropriate discuss the plan with the tāngata whai ora / service user in advance particularly where there are any changes to usual dispensing.
9.4. Holiday Schedules may be distributed to primary care practices that find them useful.
9.5. If safety is uncertain and the tāngata whai ora / service user's usual pharmacy is closed, an alternate pharmacy can be arranged for all or some of the dates particularly for longer public holidays.
9.6. A maximum of four consecutive takeaways (depending on the holiday schedule) may be authorised if:
a) the tāngata whai ora / service user's usual pharmacy is closed and the tāngata whai ora / service user is considered stable in treatment.
b) the tāngata whai ora / service user's usual pharmacy is open but takeaways are considered appropriate.

10. Alternative Dispensing Places

10.1. <u>Travel in New Zealand</u>
a) Tāngata whai ora / service users may need or want to travel in New Zealand for work or family or personal reasons. Non-urgent requests require 3 working days' notice to the team to ensure processing of such requests.
b) Urgent requests (e.g. funeral / family sickness) are processed as expediently as possible, within the constraints of the available resource. See 8. Changes to Prescribing, Urgent Prescriptions or Changes to Dispensing. For stable tāngata whai ora / service users consider takeaway doses to aid travel. Discuss this request at MDT. Tāngata whai ora / service users are given Information sheet 8 OST and holidays

10.2. Overseas travel

The OST service supports tāngata whai ora / service users wishing to travel overseas, taking the following into account:

a) The tāngata whai ora / service user must provide detailed written travel documentation (e.g. flight booking)
b) In some countries OST is unavailable and / or opioid importation is illegal. For information on requirements contact the necessary consulate(s) and / or check the international methadone travel guide on http://indro-online.de/travel.htm
c) At least four weeks' notice is usually needed but the OST service will assist, where possible, in an emergency
d) Takeaway doses depend on tāngata whai ora / service user stability (See 4. Takeaway doses)
e) Temporary overseas discharge may be preferable
f) A comprehensive summary should be sent for overseas discharge (temporary or permanent)
g) Methadone takeaway doses will be in tablet form rather than liquid (to prevent leakage during transit) and the script is written by a prescribing medical practitioner on the H572 CD Form (rather than the H572M), with the need for tablets being clearly identified
h) Medication should be kept in its dispensed packaging with the labelling attached
i) Medsafe regulations allow for a maximum of 30 days of an opioid script to be exported from NZ.
j) The OST service should ideally manage proceedings for shared care tāngata whai ora / service users as well
k) Refer to Overseas Travel Letter template
l) Information needed for overseas travel:

***Provided by* tāngata whai ora / service user:**	• Copy of itinerary with intended destination, route and duration of stay • Visa limitations information via relevant authority, if available

***Given to* tāngata whai ora / service user:**	• Prescriber's letter (see Appendix : Letter for Overseas Travel letter template)
	• Brief treatment summary for local service as required including the OST service contact details
	• Tāngata whai ora / service user responsibility for outcomes/ potential treatment requirements (e.g. possible costs overseas for medication, dispensing)
	• Where available, information on :
	  ○ Potential OST services in the area of travel
	  ○ Legality of OST medication importation

Information given to Pharmacy:	• Phone contact to update Pharmacist about the pending prescription, if any [e.g. pharmacy may need to arrange a supply of methadone tablets] • Medication prescription for travel, if any • Changes to Dispensing form for cancellation of doses, if any • Arrangements made for return to New Zealand, if any

10.3. Custody, remand and prison

a) OST is initially prescribed in prison by the tāngata whai ora / service user's service of origin. This may be negotiated on a case by case basis for tāngata whai ora / service users who are sentenced to prison for extended periods of time. For longer-term care, the prison prescriber may be authorised to prescribe in a shared care approach.

b) Dose increases are not generally supported whilst the tāngata whai ora / service user is in prison.

c) Specific pharmacies are contracted to supply designated prisons and, because they often deliver to the prisons weekly, the date on the script is often required to be amended to reflect this delivery date. The Pharmacists manage this amendment.

d) BOPAS OST retains contact where possible with imprisoned tāngata whai ora / service users for treatment continuity. The tāngata whai ora / service user continues attending routine reviews via video link. .

e) The prison should be reminded to contact OST before releasing the tāngata whai ora / service user to support continuation of care and minimise the risk of overdose.

Opioid-using tāngata whai ora / service users who leave prison (or rehab or 'detox') are at higher risk of overdose.

f) After-hours custodial detention or incarceration

i. As soon as the OST service is advised of a tāngata whai ora / service user's incarceration, all efforts will be made to ensure a dose is supplied as soon as possible. After hours it is likely the notification will be received by the acute care team (crisis), who will inform the case manager as soon as possible within business hours.

ii. If the tāngata whai ora / service user has missed 3 or more doses of OST, consult the BOPAS OST medical practitioner to review the options including:

- the tāngata whai ora / service user to be reviewed by the prison medical practitioner for withdrawal symptoms, with advice from the OST medical practitioner.
- whether any OST can safely be given without review.

10.4. Hospital

a) Hospitals are to contact BOPAS OST prior to issuing OST in order to confirm the dose and recent dispensing.

b) Useful clinical information is also discussed such as reason for the hospital admission and tāngata whai ora / service user's presentation with consideration being given to:

i. Any evidence of misuse of OST that may have led to admission e.g. intravenous use, sedation.

ii. Any clinical presentation that might impact on the existing OST treatment e.g. hepatic or renal impairment, pain, compromised physical health etc.

c) Once confirmed that the tāngata whai ora / service user is hospitalised:
   i. BOPAS OST
      - Cancels or suspends the existing community script or for a GPSC tāngata whai ora / service user lets the GP know about the admission
      - Discusses with the OST medical practitioner about the admission circumstances and formulate a plan which may include review of treatment dose or dispensing arrangements, medical review after discharge etc.
      - Prepares an authorization to prescribe to the treating medical practitioner in the hospital and faxes signed authorisation to ward and in-patient Pharmacy.
      - Liaises with hospital about progress and discharge.
   ii. The hospital:
      - After confirming the tāngata whai ora / service user's dose with BOPAS OST as above, prescribes and administers OST for the tāngata whai ora / service user for the duration of the hospitalisation. as per CPM.M3.27
      - Liaises with BOPAs OST about discharge timing so that OST can recommence at the right time and at the right place.
      - A copy of drug chart and the CD requisition book should be sent to the in-patient pharmacy to order OST for tāngata whai ora / service user. Administer and observe OST consumption. Appropriate observations to be recorded on FM.C10.1

10.5. Other: Rehabilitation/Women's Refuge/Social detox/WINGS etc

a) Other organisations may contact BOPAS OST for an amendment to the dispensing arrangements. These should be discussed with the clinical lead and medical practitioner regarding the process of prescribing and dispensing.

REFERENCES

- Deering, D. 2007. Methadone Maintenance Treatment in New Zealand. Unpublished thesis.
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- McKay, J. et al. 2005. The Effectiveness of Telephone-Based Continuing Care for Alcohol and Cocaine Dependence. Archives of General Psychiatry 62: 199-207
- World Health Organisation. 2008. Integrated Health Services: What and Why. Technical brief No. 1.
- Rollnick S. & Miller W.R. 1995. What is motivational interviewing? Behavioural and Cognitive Psychotherapy 23: 325-334
- Single, E. 1995. Defining harm reduction. Drug & Alcohol Review 14 (3): 287 - 90
- Ministry of Health. 2014. New Zealand Practice Guidelines for Opioid Substitution Treatment. Wellington: Ministry of Health
- NZ Formulary. methadone hydrochloride
- NZ Formulary. buprenorphine + naloxone
- NZ Formulary. codeine phosphate

- New Zealand Datasheet. Biodone Oral solution. Biomed Limited. 14 December 2022
- New Zealand Datasheet. Buprenorphine Naloxone BNM. BNM Group. 19 August 2022

ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.1.1 Informed Consent
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 4.1.0 Infection Prevention and Control Management
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M3.27 Medication - Methadone / Suboxone - Management of Patients Admitted who are on an Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.2 Pharmacist Dispensing Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.3 Admission to Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.4 Opioid Substitution Treatment (OST) Client Pathway
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.5 Opioid Substitution Treatment (OST) Managing Co-existing Conditions
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.6 Opioid Substitution Treatment (OST) Prescribing and Dispensing
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services OST Overseas Travel Letter template
- Te Whatu Ora Hauora a Toi Bay of Plenty BOP Addiction Service OST SOP
- Te Whatu Ora Hauora a Toi Bay of Plenty Form FM.C10.1 Clinical Opiate Withdrawal Scale (COWS) Observation Record

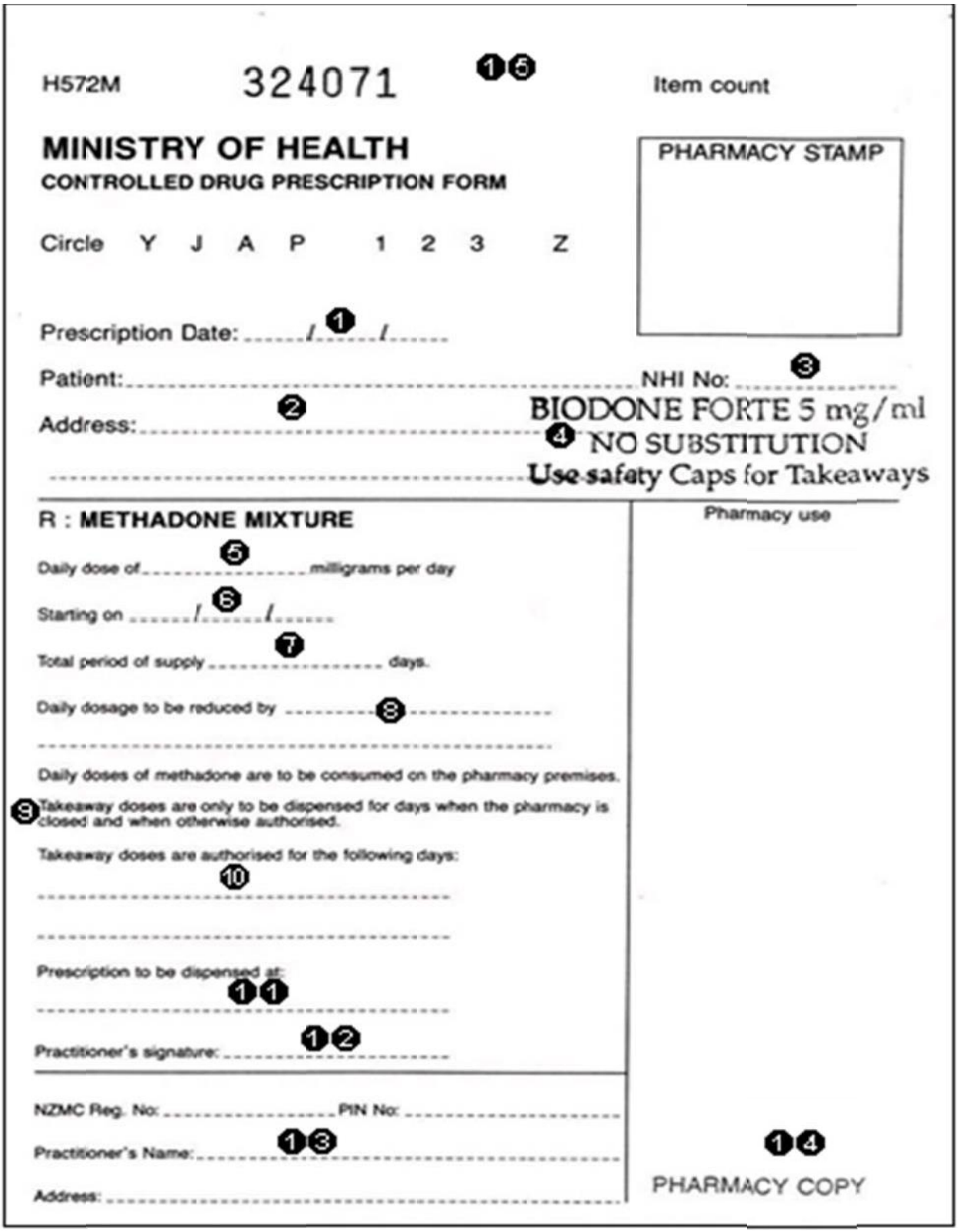
Appendix 1: Prescribing Changes

Prescribing Changes		Indications: Tāngata whai ora / service user request, or Clinical indication	Process / forms required
Dose change	Increase	Tāngata whai ora / service user requests an increase in dose	Ideally, planned at tāngata whai ora / service user review appointment with the medical practitioner and key worker. Urgency based on risk formulation. Dose changes (including reduction or increase) require replacement prescription.
		Clinical indication: e.g. Undertreated dependence	
	Decrease	Tāngata whai ora / service user requests a decrease in dose	
		Clinical indication: e.g. Sedation, interactions, contraindications	
	Cessation	Tāngata whai ora / service user requests cessation of treatment	Ideally, planned at tāngata whai ora / service user review appointment with the medical practitioner and key worker. Cancel the existing script and prepare a new prescription. Note: Service-initiated involuntary withdrawal is rare and requires strict adherence to process according to Guidelines
		Clinical indication: e.g. Contraindications / significant risks to continuing OST	
Medication change	Change of OST	Tāngata whai ora / service user request or clinical indication (e.g. Adverse effects, sedation, interactions, contraindications)	Ideally, planned at tāngata whai ora / service user review with the medical practitioner and key worker. The key worker, medical practitioner and nurse liaise about a suitable transition process.
Other issues which may require a new script	Lost scripts	*See 8.1 Lost Scripts*	
	Missed dose(s)	*See 8.2 Missed Doses*	
	Vomited dose	*See 8.5 Vomited Dose*	

Appendix 2: Dispensing Changes

Dispensing changes	Temporary examples	'Permanent' examples	Examples of urgent	Process / Forms
Place: (Dispensing Pharmacy) *See 10. Alternative Dispensing Places*	Holiday / Travel Work requirements Personal situation Funeral / Family Hospital Custody Women's Refuge	Change of address (in / outside District) Imprisonment	Acutely hospitalised or taken into custody Tāngata whai ora / service user has short notice of change in work situation Family sickness or death out of town Urgent entry to Women's Refuge	Requires new script for each new pharmacy unless hospitalised (hospital prescribes). The new pharmacy must be trained in that treatment. Unrequired scripts must be suspended (if tāngata whai ora / service user will return there) or cancelled using *C.T.D**. Reinstatement of suspended script requires *C.T.D*
Days: (Takeaway (T/A) days vs. Consumed at pharmacy) *See 4. Takeaway Doses*	Travel / Holiday Personal situation requiring additional T/A	Tāngata whai ora / service user request to increase / reduce takeaways Change in stability / clinical picture Assist recovery / GP Shared-Care	Unforeseeable personal situation Decline in stability or compromised clinical presentation	Discuss with medical practitioner and / or MDT Decline in stability or compromised clinical presentation may need review. Increased / reduced T/A needs C.T.D. and signed by medical practitioner. Consider use of an agent. *See 7.2*
Withholding a dose *(See 6.1)*	A dose on a given day may be suspended for several hours for clinical indication.			See 6.1 *Withheld Doses*

Appendix 3: H572M Methadone Script



H572M 324071 ⑮ Item count

MINISTRY OF HEALTH
CONTROLLED DRUG PRESCRIPTION FORM

PHARMACY STAMP

Circle Y J A P 1 2 3 Z

Prescription Date: ..../①.../.....

Patient:..... NHI No: ③.....

Address: ②..... BIODONE FORTE 5 mg/ml

④ NO SUBSTITUTION

..... Use safety Caps for Takeaways

R : **METHADONE MIXTURE**

Pharmacy use

Daily dose of ⑤..... milligrams per day

Starting on ...../⑥.../.....

Total period of supply ⑦..... days.

Daily dosage to be reduced by ⑧.....

.....

Daily doses of methadone are to be consumed on the pharmacy premises.

⑨ Takeaway doses are only to be dispensed for days when the pharmacy is closed and when otherwise authorised.

Takeaway doses are authorised for the following days:

⑩.....

.....

Prescription to be dispensed at:

⑪.....

Practitioner's signature: ⑫.....

NZMC Reg. No:..... PIN No:.....

Practitioner's Name: ⑬.....

Address:.....

⑭

PHARMACY COPY

Guide to writing H572M Script for Methadone:

1. Actual date* from which Pharmacist is to dispense.
   Dispensing must begin by 8th day from this date (incl) or prescription will be no longer valid.
2. Name and current residential address of tāngata whai ora / service user (do not use the pharmacy address).
3. NHI number.
4. Biodone Forte stamp is used for manual scripts. Stamp on all four copies unless using other formula, (e.g. Biodone 2 mg / mL or Biodone Extra Forte 10 mg / mL).
   Note: Place stamp next to tāngata whai ora / service user address – do not place within "Pharmacy Use" column.
5. Write current dose in numeric and word form, e.g. 80 (eighty) mg.
   For split dosing, write the total daily dose in figures and in words. Add details of how the dose is to be split and clear instructions as to which part of the dose is supervised and which, if any, is dispensed as takeaway dose.
   Note: if tāngata whai ora / service user reducing, the new prescription should state current dose as starting dose, and adjust for reduction to allow Pharmacist to automatically adjust dose.
6. Write actual start date again. Ensure it is a consumption day. Write end date of script preferably
7. Total period of supply up to maximum of 28 days. If at 2 pharmacies, specify number of doses over 28 days.
8. Specify the maximum rate of a withdrawal regimen.
9. Cross this sentence out to prevent confusion.
10. Write days for which takeaways are authorised e.g. for a tāngata whai ora / service user who collects and consumes on Mondays and Thursday write 'Tuesday, Wednesday, Friday, Saturday, Sunday.'
11. Name of pharmacy.
12. Sign prescription.
13. Stamp or printed NZMC Reg. No., medical practitioner's name and BOPAS OST address on all 4 copies.
14. Top 3 copies posted to pharmacy. Retain blue copy on tāngata whai ora / service user file.
15. If this script replaces another script, write "replaces script no. xxxxxxx."

*Note: The prescription date and the start date are usually the same. The prescription date may be earlier than the start date when the tāngata whai ora / service user is collecting medication early e.g. for taking on holiday, or incarcerated.

Appendix 4: Buprenorphine Script

A4

PRESCRIPTION

Item Count

Bay of Plenty Addiction Service (BOPAS)
Tauranga Hospital | Cameron Road
Tauranga
Ph 07 579 8391 | Fax 07 571 8095

Rx Subsidy

FULL NAME OF PRESCRIBER... *please print clearly*

DOCTOR

PROF. GROUP *(e.g. doctor, nurse practitioner etc.)*

PROF. REG. No.

PHARMACY STAMP

TO:

Patient name, NHI, full residential address *(or affix patient label)*

Start date:
Finish date:
_____ Doses over ____ days

Rx

Pharmacy Annotations

BUPRENORPHINE + NALOXONE 8mg/2mg or 2mg/0.5mg
Take DOSE mg SUB LING daily.
Dispense as observed daily consumption (with TA doses for enter take away regimen here). Crumble all observed doses and allow to dissolve under the tongue. (Reduce by X mg per day/week etc. at request).
CHEM: XXXXXXXXXX **EXP:** XX/XX/XXXX

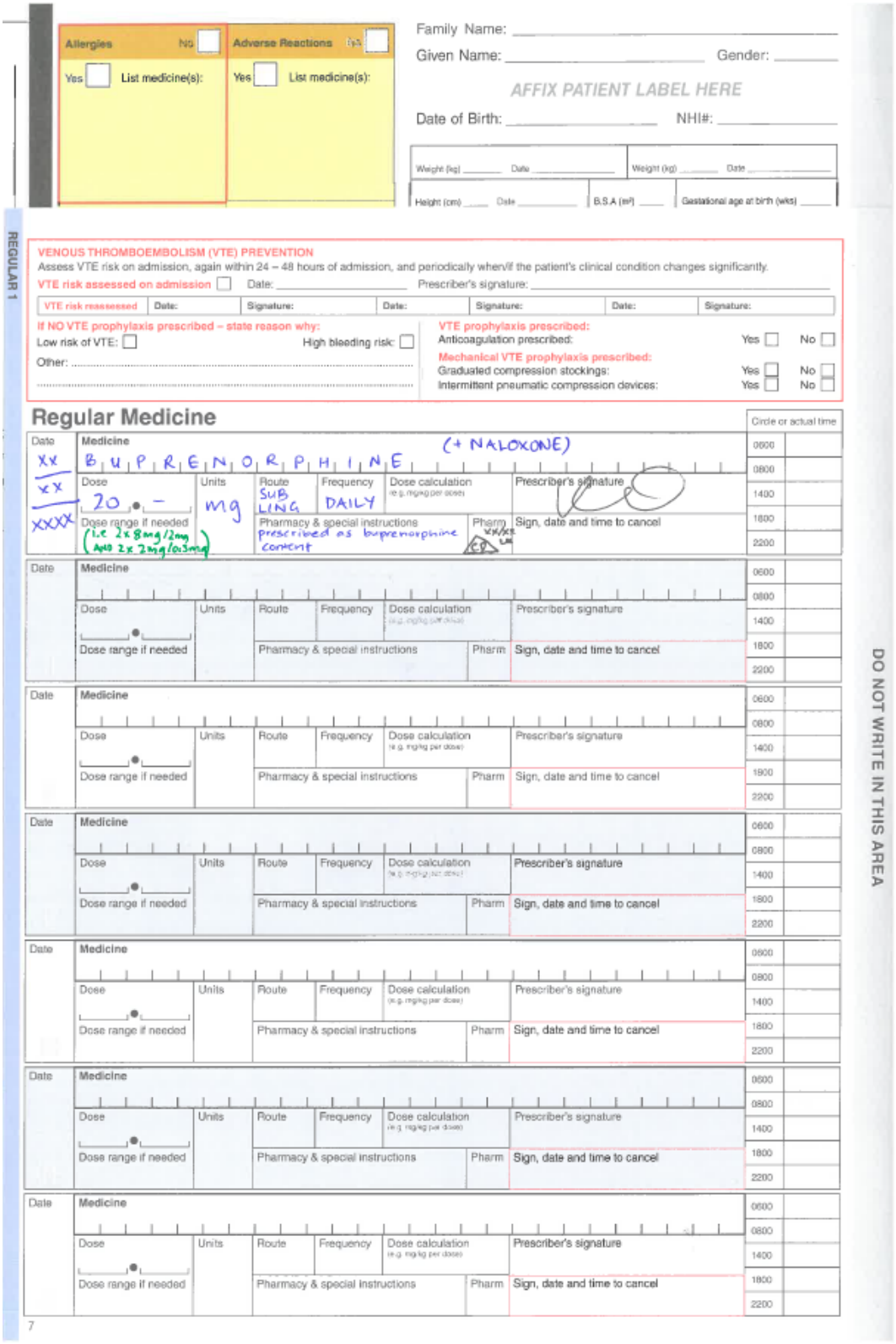
NAME OF CONSULTANT

SIGNATURE OF PRESCRIBER

/ /
DATE

If faxing prescriptions, the original MUST be mailed to the community pharmacy and NOT given to the patient or relative

Appendix 5: Buprenorphine Medication Charting example



Allergies NKA ☐ Yes ☐ List medicine(s):
Adverse Reactions NKA ☐ Yes ☐ List medicine(s):

Family Name:
Given Name: Gender:
AFFIX PATIENT LABEL HERE
Date of Birth: NHI#:

Weight (kg) Date | Weight (kg) Date
Height (cm) Date | B.S.A (m²) | Gestational age at birth (wks)

REGULAR 1

VENOUS THROMBOEMBOLISM (VTE) PREVENTION
Assess VTE risk on admission, again within 24 – 48 hours of admission, and periodically when/if the patient's clinical condition changes significantly.
VTE risk assessed on admission ☐ Date: Prescriber's signature:

VTE risk reassessed	Date:	Signature:	Date:	Signature:	Date:	Signature:

If NO VTE prophylaxis prescribed – state reason why:
Low risk of VTE: ☐ High bleeding risk: ☐
Other:

VTE prophylaxis prescribed:
Anticoagulation prescribed: Yes ☐ No ☐
Mechanical VTE prophylaxis prescribed:
Graduated compression stockings: Yes ☐ No ☐
Intermittent pneumatic compression devices: Yes ☐ No ☐

Regular Medicine

Date	Medicine	Dose	Units	Route	Frequency	Dose calculation	Prescriber's signature	Circle or actual time
XX XX XXXX	BUPRENORPHINE (+ NALOXONE)	20 –	mg	SUBLING	DAILY			0600 0800 1400 1800 2200
	Dose range if needed: (i.e 2x8mg/2mg AND 2x2mg/0.3mg)	Pharmacy & special instructions: prescribed as buprenorphine content	Pharm: KW/KS CD	Sign, date and time to cancel				

DO NOT WRITE IN THIS AREA

7

Appendix 6: Medication Formulation

1. Methadone

1.1 The preferred product is a 5 mg / mL solution, free of additives for harm reduction.

1.2 When appropriate, the 2 mg / mL formulation may be considered, such as for low doses of methadone. The 10 mg / mL formulation is unsuitable, because of its high toxicity in small volumes.

1.3 Any formulation other than the 5 mg / mL or 2 mg / mL solutions may only be prescribed with the agreement of the lead medical practitioner after full discussion of the options by the tāngata whai ora / service user's treatment team.

1.4 Locally, the Pharmacist must dispense the prescribed methadone formulation, i.e. no substitutes.

1.5 For out of area locations, the formulation may need to be crossed out, for local formulations/practices (e.g. dilution)

1.6 Methadone must not be routinely diluted, except:

a) where specifically indicated on a prescription, for example to manage a blind withdrawal

b) as part of a plan to manage diversion

c) when a tāngata whai ora / service user requests dilution (e.g. tāngata whai ora / service user seeking ways to minimise opportunities for injecting).

2. Buprenorphine / Naloxone formulation

2.1 The available current product is buprenorphine with naloxone tablets in 2 mg (2 mg buprenorphine / 0.5 mg naloxone) or 8 mg (8 mg buprenorphine / 2 mg naloxone).

2.2 Consumed doses are crumbled or quartered and administered sublingually.