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The College of Physicians & Surgeons of Manitoba

Buprenorphine/naloxone Recommended Practice Manual

In-Hospital Care

Recommendations regarding in-hospital care for individuals with opioid use disorder, including who may prescribe methadone and buprenorphine/naloxone in hospitals.

General Considerations

A period of hospitalization can present both opportunity and significant risks for individuals with an opioid use disorder. In fact, those affected by this illness often fear hospitalization due to the anticipated discomfort of opioid withdrawal and general lack of access to adequate prescribed opioids to treat withdrawal and/or pain, safe spaces to use, harm reduction supplies and support services that may be more readily available in the community. This can lead to affected individuals avoiding hospitalization despite medical need, or postponing presentation to the emergency department until their illness has progressed to critical severity.

Despite the above-mentioned risks, a planned hospital admission, or an emergency room presentation and subsequent admission, may present a valuable opportunity for addiction medicine intervention and further care planning. Hospitalization also presents an opportunity for patients already on opioid agonist therapy to be assessed and observed with a view on optimizing OAT dosing, addressing concurrent substance use issues, medical and mental health conditions and the need for more intensive community-based supports.

In this section we will be addressing several important issues related to caring for individuals with an opioid use disorder in hospital. We will pay special attention to the importance of continuity of care between health care facilities and the community.

Specific Recommendations

Who may prescribe methadone and buprenorphine/naloxone in hospital?

Please note that the federal methadone exemption no longer exists. Both methadone and

buprenorphine/naloxone prescribing approvals are now provincially regulated by the health care provider's relevant medical regulatory authority (the CPSM for physicians; CRNM for RN(Nurse Practitioners)).

Methadone is included in this section for ease of reference for hospital administrators, care providers and regulators.

Recommendations in this section are guided by the principles of access to care, continuity of care, equity, patient safety and optimal utilization of current expert resources.

Continuing care in hospital

A licensed physician/RN(Nurse Practitioner) practicing in a hospital in Manitoba does not need to apply for approval to prescribe methadone or buprenorphine/naloxone for continuation of therapy as long as the patient:

- is an inpatient of the hospital,
- is under their care,
- is currently on methadone or buprenorphine/naloxone in the community, and
- is prescribed the same dose or a lower dose as in the community.

For dose increases, new methadone or buprenorphine/naloxone starts or restarts in hospital, including take-home (carry) dosing recommendations, please refer to the section below.

Dose increases

For methadone and buprenorphine/naloxone, dose increases are permitted in hospital if the licenced physician/RN(Nurse Practitioner) caring for the patient documents a discussion with the patient's community OAT prescriber or a physician member of the Health Sciences Centre Addiction Consult Team. The on-call physician can be reached by contacting Health Sciences Centre paging. The in-patient order needs to include the phrase 'as discussed with Dr. _____ (name of the approved prescriber the increase was discussed with)'.

New starts

For methadone and buprenorphine/naloxone, new starts (inductions) are permitted in hospital if the licensed physician/RN(Nurse Practitioner) caring for the patient documents a discussion with a physician member of the Health Sciences Centre Addiction Consult Team. The on-call physician can be reached by contacting Health Sciences Centre paging. These on-call physicians have the expertise to determine if a methadone or buprenorphine/naloxone start by an

inexperienced prescriber of OAT is advisable with phone guidance from the HSC consult physician. Several factors are considered in this decision, including the patient's overall health and medication regimen, current acute medical and mental health conditions, the hospital environment, in-patient care resources and staffing level as well as available options for continuing OAT care in the patient's home community post discharge.

A telehealth consultation may be suggested by the consulting physician to facilitate an enhanced remote patient assessment and appropriate care recommendations. However, this is at the discretion of the consulting physician and not a requirement.

In-patient orders for new starts need to include the phrase 'as discussed with Dr. _____ (name of the approved physician from the HSC Addiction Consult Team)'.

Restarts

An in-patient restart of methadone or buprenorphine/naloxone is defined as a methadone or buprenorphine/naloxone induction in an in-patient who was prescribed methadone or buprenorphine/naloxone for opioid agonist therapy in the community during the 30 days preceding hospital admission AND treatment was discontinued for a minimum of 3 days for methadone or 6 days for buprenorphine/naloxone prior to the admission date.

For methadone and buprenorphine/naloxone, restarts are permitted in hospital if the licenced physician/RN(Nurse Practitioner) caring for the patient documents a discussion with a physician member of the Health Sciences Centre Addiction Consult Team. The on-call physician can be reached by contacting Health Sciences Centre paging. These on-call physicians have the expertise to determine if a methadone or buprenorphine/naloxone restart by an inexperienced prescriber of OAT is advisable with phone guidance from the HSC consult physician. Several factors are considered in this decision, including the patient's overall health and medication regimen, current acute medical and mental health conditions, the hospital environment, in-patient care resources and staffing level as well as available options for continuing OAT care in the patient's home community post discharge.

In-patient orders for restarts need to include the phrase 'as discussed with Dr. _____ (name of the approved physician from the HSC Addiction Consult Team)'.

Discharge prescriptions

Hospital teams need to notify the patient's community pharmacy and community-based prescriber/clinic of the admission on the first day of admission, or as soon as possible after, to facilitate coordination around a discharge prescription and to notify them that any current OAT prescriptions must be put on hold or cancelled if needed.

It is important for hospital teams to note that **only an approved methadone or buprenorphine/naloxone prescriber may provide a methadone or buprenorphine/naloxone**

discharge prescription (on an M3P form) for continuing care at a community pharmacy. It is therefore important to involve the patient's community pharmacy and community prescriber/clinic in discharge planning as early as possible. This communication should **not** happen only at the time of discharge if it can be avoided, especially if a new M3P discharge prescription is needed to facilitate safe discharge.

For hospital admissions during which no dose changes occurred for existing methadone or buprenorphine/naloxone prescriptions, the community pharmacy may be able to reactivate the patient's existing OAT prescription that was put on hold during admission, if the end date on the prescription has not elapsed. This needs to be confirmed by the in-patient team (in-patient pharmacist or treating physician if no pharmacist available) prior to discharge to ensure continuity of care upon discharge.

If a dose change occurs during admission, the inpatient team is responsible for notifying the patient's community pharmacy of the dose change as soon as possible after it occurs. The pharmacy can then cancel their Rx "on hold" and try to acquire a new Rx for discharge, in case the patient comes to the pharmacy unexpectedly (e.g. they discharge themselves).

In general, a discharge prescription can be arranged by contacting the patient's community prescriber/clinic to request a new prescription be sent to the patient's pharmacy. The HSC Addiction Consult Team may be able to provide a bridging discharge prescription for patients on whom they were consulted.

For both new starts and restarts of methadone and buprenorphine/naloxone in hospital, an approved prescriber from the HSC Addiction consult team may be able to provide a bridging discharge prescription to facilitate discharge, as long as arrangements are in place for follow-up with an approved community-based OAT prescriber who will then assume responsibility for the patient's ongoing OAT care.

Clinical Assistants (CAs) and Physician Assistants (PAs)

A clinical assistant (CA) or physician assistant (PA) cannot independently prescribe methadone or buprenorphine/naloxone in hospital and cannot provide a discharge prescription for these medications.

In-patient orders for continuing care, dose increases, new starts or restarts of methadone and buprenorphine/naloxone may be signed by a CA or PA if they include the phrase 'as discussed with attending physician' on the signature line. Such orders require a documented conversation with the supervising attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

The same requirements as for attending physicians apply to CAs and PAs in terms of the need for a documented conversation with an approved prescriber as outlined above for dose increases, new starts and restarts of methadone and buprenorphine/naloxone.

Residents and Fellows

A resident may prescribe **buprenorphine/naloxone** in hospital for the purpose of continuing care at the same or lower dose.

In-patient orders for **methadone** for the purpose of continuing care at the same or lower dose may be signed by a resident if they include the phrase 'as discussed with attending physician' on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

In-patient orders for dose increases, new starts or restarts of **methadone or buprenorphine/ naloxone** may be signed by a resident if they include the phrase 'as discussed with attending physician' on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

The same requirements as for attending physicians apply to residents in terms of the need for a documented conversation with an approved prescriber as outlined above for dose increases, new starts and restarts of methadone and buprenorphine/naloxone.

Residents cannot provide a discharge prescription for methadone or buprenorphine/naloxone.

The same recommendations as for residents apply to fellows who hold an educational licence.

Fellows who hold a full licence, but who are not CPSM approved prescribers of methadone and/or buprenorphine/naloxone, must follow the same requirements as all other licensed physicians/attending physicians in hospital.

Fellows who hold a full licence and who are CPSM approved to prescribe methadone and/or buprenorphine/naloxone can order continuing care, dose increases, restarts and new starts of the medication(s) they hold an approval for.

Fellows cannot provide a discharge prescription for methadone or buprenorphine/naloxone unless the fellow holds a full licence **and** the relevant CPSM approval to prescribe methadone and/or buprenorphine/naloxone.

Take-home dosing (carries)

A licensed physician can, at their discretion, prescribe a "pass med" to an inpatient who is temporarily leaving the hospital and is returning back to the hospital. One or more methadone or buprenorphine/naloxone dose(s) must be dispensed by the hospital pharmacy and the patient must still be a patient of the hospital. Methadone or buprenorphine/naloxone should **only** be provided as a “pass med” if the patient was previously receiving carries in the community and continues to meet the requirements for take-home dosing in the community as outlined elsewhere in this manual. If the hospital prescriber is in doubt, take-home doses should first be discussed with the patient’s community OAT prescriber. The hospital pharmacy should notify the community pharmacy of any such pass meds provided to prevent double dosing.

Hospitals cannot provide take-home methadone doses to facilitate discharge. A discharge prescription needs to be arranged as already outlined before discharge can occur.

For buprenorphine/naloxone, one to two take-home doses provided by the hospital pharmacy is acceptable if discharge is unexpected or occurs on a weekend or holiday and the inpatient team is unable to reach the community OAT prescriber. The community pharmacy needs to be notified of any take-home doses provided upon discharge or as soon as possible to prevent double dosing. The community OAT prescriber/clinic needs to be notified as soon as possible after discharge as well.

CAs, PAs, residents and fellows with an educational licence can sign pass med orders and orders for one to two take-home doses of buprenorphine/naloxone upon discharge if they include the phrase ‘as discussed with attending physician’ on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

CAs, PAs, residents and fellows with an educational licence can sign pass med orders for methadone if they include the phrase ‘as discussed with attending physician’ on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**