

College of Pharmacists
of British Columbia



Professional Practice Policy #66

Policy Guide
Methadone Maintenance Treatment (2013)

Forward

Opioid use disorder is a health concern with implications for the individual patient as well as the public. The choice of opioid agonist treatment (OAT) for opioid use disorder (OUD) is an individually tailored process whereby clinicians discuss the risks and benefits of all three oral OAT options (i.e. methadone, buprenorphine/naloxone, and slow-release oral morphine) with patients and taking a patient-centred approach, collaboratively, select a medication that aligns with the patient’s goals, treatment history and other individual circumstances. Opioid use disorder is recognized as a chronic relapsing condition. Opioid agonist treatment is recommended as the standard of care for people with OUD.

Many studies, conducted over several decades in different countries, have clearly demonstrated that the effective delivery of methadone maintenance treatment (MMT) reduces non-medical opioid use, other problematic substance use, criminal activity, mortality, injection-related risks and transmission of blood-borne disease. Additional positive results are improvement in physical and mental health, social functioning, quality of living and pregnancy outcomes.

Methadone, a long-acting, orally effective opioid, is used as a substitute for opioids when treating opioid use disorder. Methadone eliminates withdrawal from and reduces cravings for, opioids. Methadone does not produce euphoria, and it blocks the euphoric effects of other opioids. When used in the treatment of opioid use disorder, a single oral dose of methadone is effective for at least 24 hours. Eventual withdrawal from methadone is not necessarily the goal of the program, although some individuals may work with their prescriber and pharmacist to decrease their dose and eventually stop using methadone.

Methadone prescribing is controlled by both federal and provincial legislation, as well as administrative procedures and guidelines.

Registered pharmacists are permitted to purchase and dispense methadone without federal exemption. However, the College of Pharmacists of British Columbia (CPBC) *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* (see Appendix 1 for a link to this document) requires that the pharmacy manager and all staff pharmacists employed in a community pharmacy that provide services related to MMT know and apply the principles and guidelines in the *CPBC MMT Policy Guide*.

How to Use This Guide

This Policy Guide (the Guide) is a companion to *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* (Appendix 1). The intention of the MMT *Guide* is to provide pharmacists with further detail and clarity (including practical examples) to assist in the implementation of the policy into practice to ensure consistency in the safe and effective delivery of methadone maintenance treatment services. In addition to PPP-66 and the MMT Policy Guide, evidence-based recommendations and clinical guidance can be found in the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*.

The expectation is that pharmacists will practice in compliance with legislative requirements, including the principles outlined in this *Guide*. While pharmacy practice is not always ‘black and white’ when navigating the ‘grey’ pharmacists must use sound professional judgment, ensuring that their decisions are made in the best interest of the patient and with appropriate collaboration, notification and most importantly, documentation.

Note:

This document is not intended to cover all possible practice scenarios.

Acknowledgement

The development of this *Guide* involved a collaborative and consultative process with input and feedback gathered from a volunteer group of dedicated community pharmacists currently engaged, in varying capacities, in the delivery of methadone maintenance treatment services.

The group was comprised of both frontline pharmacists and pharmacy managers and represented a cross-section of practice types (independent to large chain retailers) and practice settings including pharmacies located in Vancouver’s Downtown Eastside whose primary focus is on the provision of methadone maintenance treatment.

Feedback was also solicited from other stakeholder groups including; the Ministry of Health Services, the College of Physicians and Surgeons of BC, the BCPhA, the City of Vancouver, patient advocacy groups Vancouver Area Network of Drug Users (VANDU), and the BC Association for People on Methadone (BCAPOM).

The College of Pharmacists of BC would like to sincerely thank each of these individuals and organizations for their invaluable feedback in the creation of this significant resource for pharmacists.

Methadone Maintenance Treatment Policy Guide

In accordance with *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* (Appendix 1), all pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must know and apply the principles and guidelines outlined here in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions. The responsibility of pharmacy technicians in the dispensing of MMT is consistent with their scope of practice outlined in the *Health Professions Act (HPA) Bylaws Schedule F Part 1 section 4*.

1.0 Administration

1.1 General

Principle 1.1.1 Refer colleagues, prescribers, and clinical staff to the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder (OUD Guideline)*.

Recommend completion of online training through the University of British Columbia, Faculty of Medicine Continuing Professional Development's Provincial Opioid Addiction Treatment Support Program.

1.2 Pharmacy Operating Hours

Principle 1.2.1 The pharmacy hours of service must be consistent with the supervised dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily witness ingestion (i.e., 7 days per week) the pharmacy hours of service must accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for MMT from 'daily witness' to a 'take-home' dose.

1.3 Privacy and Confidentiality – Premise

Principle 1.3.1 All pharmacies offering methadone maintenance treatment must be in compliance with all relevant legislation pertaining to the structure of the licensed premise with particular attention given to ensuring there is sufficient space to accommodate patients waiting for witnessed ingestion and/or take home methadone doses while simultaneously maintaining privacy for pharmacist-patient consultation.

Guideline: It may be appropriate to establish a staggered schedule for regular patients requiring witnessed ingestion to ensure that there is adequate space within the pharmacy to accommodate patients who are waiting and ensure privacy of pharmacist-patient consultation.

1.4 Security – Premise

Principle 1.4.1 All pharmacies offering methadone maintenance treatment must ensure that their pharmacy is in compliance with all relevant legislation pertaining to pharmacy security requirements including those outlined in *Professional Practice Policy (PPP-74) – Community Pharmacy and Telepharmacy Security*.

2.0 Receiving Methadone Prescriptions

2.1 Controlled Prescription Program Forms – Overview

Principle 2.1.1 Methadone maintenance prescriptions can only be accepted when written using an approved Controlled Prescription Program (CPP) form. When accepting methadone maintenance prescriptions, the pharmacist must ensure that the CPP form is completed by the prescriber as outlined in the CPP. The pharmacist must ensure the patient signs the bottom of the form in the space indicated.

See Principle 4.1.3 for signing procedures when releasing a methadone prescription.

Principle 2.1.2 MMT prescriptions may only be received by **facsimile** in accordance with section 7(3) of the *Health Professions Act* Bylaws Schedule F, Part 1 – Community Pharmacy Standards of Practice. A CPP form can only be accepted by facsimile during a public health emergency declared by the Provincial Health Officer. This includes the ongoing Overdose Crisis declared under the *Public Health Act*.

Prescriptions may only be accepted **verbally** where permitted under a section 56 exemption to the *Controlled Drugs and Substances Act* in accordance with section 19(6.1) of the bylaws to the *Pharmacy Operations and Drug Scheduling Act*. The pharmacy must receive either the original or a faxed copy of the CPP prescription form from the prescriber as soon as reasonably possible.

Principle 2.1.3 In an effort to maximize the effectiveness of the methadone maintenance treatment program, the pharmacist may find it beneficial to engage in a specific dialogue with the patient, either when they initiate treatment or at various times throughout treatment, that clearly outlines the expectations of both the patient and the pharmacist.

Principle 2.1.4 In the rare circumstance (disruptive or threatening behavior or verbal or physical abuse) where a pharmacist finds that they must terminate the pharmacist-patient relationship, reasonable notice must be provided to the patient to ensure their continuity of care.

Guideline: It is important to remember that the decision to terminate a pharmacist-patient relationship is a serious one and must be made with due consideration and based on appropriate rationale. It is unethical for a pharmacist to terminate the pharmacist-patient relationship or refuse to treat a patient on morally irrelevant grounds. The pharmacist's decision should be documented and retained in the patient record.

2.2 Controlled Prescription Program Forms – Alterations

Principle 2.2.1 Alterations to the approved Controlled Prescription Program form are the exception to the rule and should not be normal practice as they increase the likelihood of errors and drug diversion and put the public at risk. In the rare circumstance when an alteration is necessary to ensure the continuity of care pharmacists must always use due diligence to ensure authenticity and accuracy of the prescription.

Guideline:

Alterations completed at the prescriber’s office: Alterations are only permitted on the sections of the form that the prescriber completes provided that the prescriber has initialed the alteration. Alterations are not permitted to the pre-printed sections of the form.

Alterations completed at the pharmacy: Pharmacists do not have independent authority to make any alterations or changes to the approved Controlled Prescription Program form. Any required or requested change(s) must be patient-specific and authorized by the patient’s prescriber through direct consultation with the pharmacist. Any prescriber-authorized changes must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication whenever possible and attached and filed with the original prescription.

Note: The *Pharmacist-Prescriber Communication Form* (Appendix 4) can be used for this purpose.

2.3 Out-of-Province Prescriptions

Principle 2.3.1 Pharmacists are permitted to dispense methadone prescriptions from prescribers in provinces other than BC.

Guideline: If there are any doubts regarding the authenticity of the out-of-province prescription, the pharmacist must contact the out-of-province prescriber to confirm the legitimacy of the prescription. When satisfied that the prescription is authentic, the pharmacist can dispense and process the prescription in the same manner as other prescriptions from out-of-province prescribers.

Note: It's important to realize that not all provinces are required to use Controlled Prescription Program forms.

3.0 Processing (Dispensing) Methadone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Refer to PPP-66 '2. Methadone Maintenance Policy Statements' for acceptable drug dispensing and exceptions.

Principle 3.1.2 Positive identification is required for all patients presenting a prescription for the first time, and reasonable steps to positively identify the patient must be taken prior to dispensing any subsequent prescriptions.

Guideline: The CPBC *Professional Practice Policy (PPP-54) – Identifying Patients and Patient Representatives in Community Pharmacy and Telepharmacy Settings* provides guidance for registrants on taking reasonable steps to confirm the identity of the patient. The prescriber may be contacted to assist with verifying the patient's identity, if necessary.

Principle 3.1.3 Pharmacists and pharmacy technicians must review the prescription to ensure that it is completed by the prescriber as outlined in the Controlled Prescription Program, and that the directions for use appropriately meet the specific needs of the patient and can be accommodated by the pharmacy

Guideline: Each prescription must be reviewed in detail in consultation with, and consideration given to the specific needs of, the patient. The following list is a sample only:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a weekend when the patient will not be able to see a prescriber for a new prescription.
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, divided dose, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.
- Confirm that stamped or preprinted sticker directions do not conflict with written directions.

College of Pharmacists of British Columbia

Any ambiguous or conflicting information identified must be clarified with the prescriber. Should an alteration or change to the prescription be required, it must be done in compliance with the Principles and Guidelines outlined in section 2.2.

3.2 Assessment of a Prescription

Principle 3.2.1 Pharmacists and pharmacy technicians must correctly identify the product as prescribed ‘for pain’ or ‘for opioid use disorder’ by using the appropriate Drug Identification Number (DIN) or Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

Principle 3.2.2 As with all medications a pharmacist **must** review each individual PharmaNet patient record, as stated in *HPA Bylaws* (Schedule F Part 1) and resolve any drug-related problems prior to dispensing any methadone prescription. This step is particularly critical for methadone prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system does not include methadone. Pharmacists providing methadone maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to methadone. General information in this regard can be found in Appendix 5.

Guideline: A PharmaNet patient record review must be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3 Should a patient present a prescription for a mood altering drug or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of methadone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the methadone maintenance program.

Guideline: The pharmacist should document the outcome of the consultation(s) with the prescriber(s) and attach it to the original prescription.

Principle 3.2.4 The ‘sig field’ on the prescription label must include the start and end dates of the original current prescription.

Principle 3.2.5 As required by *HPA Bylaws* Schedule F Part 1 the ‘dispensing date’ on the prescription label must accurately reflect the actual date dispensed on the PharmaNet system.

3.3 Preparing Methadone Prescriptions

Principle 3.3.1 Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 ml.

Guideline: All devices used to measure the methadone 10 mg/ml solutions should be distinctive and recognizable and must be used only to measure methadone solutions. Devices must be labeled with a ‘methadone only’ label and a ‘poison’ auxiliary label with the international symbol of the skull and cross bones.

Principle 3.3.2 Reconciliation procedures must be conducted in accordance with *Professional Practice Policy (PPP-65) – Narcotic Counts and Reconciliations*.

Guideline: Reconciliation means the quantity of methadone on hand must equal the quantity received minus the quantity dispensed over a specific period of time.

3.4 Loss or Theft and Disposal of Methadone

Principle 3.4.1 The *Narcotic Control Regulations* require that pharmacists report the loss or theft of controlled drugs and substances to the Office of Controlled Substances, Health Canada within 10 days of the discovery of the loss or theft. In the event of a loss or theft the pharmacy should also notify the CPBC within 24 hours.

Guideline: The form for reporting loss or theft of narcotics can be found on the CPBC website www.bcpharmacists.org under *Resources*.

3.5 Methadone in Tablet Form for Air Travel

Principle 3.5.1 Hand luggage restrictions governing the transportation of fluids in air travel may be problematic for patients and in certain circumstances may necessitate the prescription of methadone in tablet form. Only commercially available methadone in tablet form may be dispensed. Pharmacists need to be aware that the prescription of methadone in tablet form may result in increased risk for both patients and the public. **Note:** Dispensing of methadone powder by way of sachet, capsule, or other format is never acceptable due to the increased potential for diversion and misuse.

Guideline: Long-term methadone maintenance treatment clearly limits patients' ability to travel because of the need for regular follow-up as well as the restrictions associated with the dispensing of methadone. If patients receiving MMT wish to travel for a period of time that exceeds their regular carry period, the usual standard of care should not be compromised, particularly if the patient is not stable and still requires daily supervised ingestion.

Patients are significantly limited in their ability to transport methadone across international borders but it is possible to arrange for methadone dispensing in some jurisdictions. The CPSBC advises physicians to research each case to ensure decisions do not compromise patient safety. In some cases, patients may require documentation for the purpose of crossing international borders or to assist in accessing temporary care from a methadone program at their destination. The physician is responsible to provide the required travel documentation.

4.0 Releasing Methadone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present and witness the release of a methadone prescription to a patient. This function cannot be performed by a pharmacy technician or any other pharmacy support staff, unless permitted by a section 56 exemption to the *Controlled Drugs and Substances Act*. Pharmacists are responsible for confirming whether such a section 56 exemption exists at the time of release.

Principle 4.1.2 Prior to releasing a methadone prescription, the pharmacist must assess the competence of the patient (i.e. ensure that the patient is not currently intoxicated or otherwise mentally impaired) to ensure that it is safe to release the medication to them.

Guideline: Pharmacists must assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's 'normal' behaviour in order to be able to detect significant deviations from normal.

If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and attach it to the original prescription.

Principle 4.1.3 Prior to releasing a methadone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. . The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

The patient/prescription specific log (the sample *Methadone Part-Fill Accountability Log* (Appendix 7) can be used for this purpose).

Principle 4.1.4 As with all prescriptions, prior to releasing a methadone prescription, the pharmacist must counsel the patient on the risks (including common side effects) and benefits of taking their medication as per *HPA Bylaws* Schedule F Part 1 section 12.

Guideline: The most common adverse reactions with methadone include; sweating, constipation, sexual dysfunction, change in menstruation, drowsiness, sleep disturbances, muscle and bone aches, weight changes (usually gain), skin rash, gastrointestinal upset, headaches and edema. Patients will benefit from information about the non-drug approaches, non-prescription products and prescription items that can provide relief from these side effects.

Principle 4.1.5 With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

Guideline: Given the concentrated solution of 10 mg/ml, it may be helpful to provide a glass of water to the patient to enable rinsing out of the dispensing container to ensure full dose administration.

Immediately following observing the patient's ingestion of the medication the pharmacist should engage the patient in a short conversation to ensure that the entire dose has been swallowed.

Principle 4.1.6 With respect to take-home doses the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion on the day the prescription is dispensed with all subsequent take-home doses dispensed in child-resistant packaging with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient.

Guideline: Each dose must be dispensed in individual, appropriately sized, child-resistant packaging.

Each container must be individually labeled.

If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses it must be documented on the patient record.

College of Pharmacists of British Columbia

Patients should be reminded that methadone should be stored out of the reach of children, preferably in a locked cupboard or small lock box if stored in the refrigerator.

Note: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Principle 4.1.7 In extraordinary situations, when a patient cannot attend the pharmacy, the patient’s representative may pick up and sign for their authorized take-home dose(s) if confirmed in writing by the prescriber.

Guideline: This authorization must be date specific, and the representative and circumstances must be clearly defined. The written and signed authorization from the prescriber (fax acceptable) must be attached to the approved Controlled Prescription Program form.

Note: Patient representative is defined in *HPA Bylaws*.

5.0 Responding to Methadone Dosing Issues

5.1 Divided (Split) Doses

Principle 5.1.1 Only the prescriber, by stating this on the approved Controlled Prescription Program form, can authorize a divided (split) dose of a prescription. Unless otherwise specified by the prescriber, the first portion of the daily dose must be by witnessed ingestion.

Guideline: The decision to authorize a divided dose can only be made by the prescriber, however, should a pharmacist believe that a patient would benefit from this they should discuss this option with the prescriber.

5.2 Missed Doses

Principle 5.2.1 Any methadone prescription dose that has been processed and prepared but is not consumed by the patient or picked up on the prescribed day is considered missed and must be reversed in PharmaNet before the end of the business day. If a patient misses 4 or more consecutive days, the prescription must be cancelled, and the prescriber notified.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up methadone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.2.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.2.3 The pharmacist must notify the prescriber of any missed doses (unless a specified number of missed doses has been indicated by the prescriber) before the next scheduled release of medication.

Guideline: The notification document must be retained and filed with the prescription consistent with filing retention requirements. The *Pharmacist-Prescriber Communication Form* (Appendix 4) can be used for this purpose.

Principle 5.2.4 If a patient misses 4 or more consecutive days, the prescription must be cancelled, and the prescriber notified.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

5.3 Partial Consumption of Doses

Principle 5.3.1 If a patient refuses to consume their full dose, the pharmacist must not insist that they ingest the total amount. The unconsumed portion, however, cannot be given as a take-home dose.

Guideline: The patient’s partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. *The Pharmacist-Prescriber Communication Form* (Appendix 4) can be used for this purpose.

All patient documentation including the *Methadone Part-Fill Accountability Log* (Appendix 7) and PharmaNet record must accurately reflect the actual dose consumed by the patient.

5.4 Vomited Doses

Principle 5.4.1 If a patient reports that they vomited their dose, a replacement dose cannot be provided without authorization from the patient’s prescriber.

Guideline: The pharmacist must contact the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). Should the prescriber authorize a replacement dose, it must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication and attached and filed with the original prescription.

5.5 Lost or Stolen Doses

Principle 5.5.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided without authorization from the patient’s prescriber.

Guideline: The pharmacist must contact the prescriber and discuss the situation with them. Should the prescriber determine that the situation warrants it they may authorize the acceptance of a new approved Controlled Prescription Program form by fax (refer to Principle 2.1.2) or the prescriber may advise the pharmacy that they must wait until the patient presents a new original approved Controlled Prescription Program form.

5.6 Tapering

Principle 5.6.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/ prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient’s PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication Form* (Appendix 4) can be used for the purpose of notifying the prescriber.

5.7 Emergency Dosing

Principle 5.7.1 Emergency dosing is not recommended, however, a pharmacist may provide an emergency or extended prescription dose if the pharmacist has determined in their professional judgement that an emergency dose or extension is required to ensure continuity of patient treatment. The pharmacist must counsel the patient to obtain a new prescription as soon as possible. This practice is the exception to the rule and not the normal practice, refer to *Professional Practice Policy (PPP-31) – Emergency Supply for Continuity of Care*.

Guideline: Pharmacists need to document, as per *PPP-31*, the attempt to reach the prescriber with information about the situation. The prolonged half-life of methadone ensures that a patient maintains a single dose for at least 24 hours. Although the patient may feel uncomfortable an emergency dose may not be necessary. Emergency doses may hinder treatment success and health outcomes. It is a patient’s responsibility to make sure they have a valid prescription.

6.0 Continuity of Care

6.1 Transfer of Pharmacy

Principle 6.1.1 When a patient chooses to move from one pharmacy to another to receive their methadone prescription it is the responsibility of the new pharmacy to contact the previous pharmacy and prescriber (if applicable) to discuss the exact transfer date and any other pertinent concerns. The previous pharmacy must cooperate fully with the request from the new pharmacy.

Guideline: Communication between the previous and new pharmacy is critical to ensure the patient’s continuity of care and to avoid duplicate or missed methadone doses. A review of the patient’s PharmaNet patient record can be of assistance in determining the previous pharmacy and prescriber.

6.2 Hospitalization or Incarceration

Principle 6.2.1 When a patient is discharged or released to the community from a hospital or correctional facility it is the responsibility of the community pharmacist receiving the patient to verify the date and amount of the last dose administered.

Guideline: Effective communication sharing among those who provide the patient’s methadone maintenance treatment (hospital or correctional facility and pharmacy) is essential to ensure the patient’s continuity of care and to avoid duplicate or missed methadone doses.

6.3 Compounding in Exceptional Circumstances

Principle 6.3.1 Refer to PPP-66 section ‘2. Methadone Maintenance Policy Statements’ for acceptable drug dispensing and exceptions.

Principle 6.3.2 A compounding log must be established to record when methadone solutions are prepared, how much was prepared, and who prepared the product. The *Compounding Log* (Appendix 68) can be used for this purpose.

Guideline: The compounding log must incorporate the following elements:

- Preparation date,
- Methadone powder and/or liquid concentrate manufacturer’s lot number and expiry date,
- Methadone powder and/or liquid concentrate quantity used and quantity prepared,
- Batch number and use-by date assigned by the pharmacy, and
- Preparer’s and pharmacist’s identification.

A separate compounding log must be maintained for each strength of stock solution.

Principle 6.3.3 All concentrated solution containers must be clearly labeled with the drug name, strength, use-by date and appropriate warning labels.

Guideline: If different concentrations are prepared for pain management, they must be easily identifiable with clear labeling. A best practice would be to use different styles of storage container for each concentration or use food grade dyes to differentiate between the different concentrations prepared.

In order to help ensure liquid methadone preparations remain stable for up to 30 days from the date of pharmacy dispensing and to minimize the growth of bacteria, mold and fungus the *American Association for the Treatment of Opioid Dependence* recommends that pharmacists should:

- Use distilled water for when compounding the dilution of methadone products,
- Use new, clean, light-resistant containers for dispensing,
- Refrigerate take-home containers as soon as possible and keep refrigerated until used.

Principle 6.3.4 Methadone for maintenance solutions daily doses must be dispensed to patients diluted with full-strength Tang™ or similar full-strength beverage crystals with daily doses (witnessed ingestion or take-home). Plain water is never an acceptable vehicle for dispensing to patients in the methadone maintenance treatment program.

Guideline: The beverage crystals are full-strength when made according to the manufacturer's directions found on the product's packaging.

Dispensing as a standard volume (e.g., all doses dispensed as a volume of 100 mL) is not acceptable.

Appendix 1

CPBC Professional Practice Policy PPP-66 – Opioid Agonist Treatment

See the most up-to-date *Professional Practice Policy – 66 Opioid Agonist Treatment* on the CPBC website: http://library.bcpharmacists.org/6_Resources/6-2_PPP/5003-PGP-PPP66.pdf

Appendix 2

CPBC Professional Practice Policy PPP-71 – Delivery of Opioid Agonist Treatment

See the most up-to-date *Professional Practice Policy – 71 Delivery of Opioid Agonist Treatment* on the CPBC website: http://library.bcpharmacists.org/6_Resources/6-2_PPP/5003-PGP-PPP71.pdf

Appendix 3

Emergency Fax Controlled Prescription Program Form Documentation

This form is for the use only in the event of an emergency that requires a faxed Controlled Prescription Program form which has been initiated following direct consultation between the patient’s pharmacist and prescriber.

It is understood that the pharmacist must obtain written documentation from the prescriber prior to dispensing any medication and as such is requesting that the prescriber complete this form and fax back to the pharmacy along with a fax of the Controlled Prescription Program form as soon as possible.

Prescriber: _____ Patient Name: _____

Pharmacy: _____ Fax Number: _____

Pharmacist: _____ Date: _____

As the prescriber, I request that the above-named pharmacy accept a faxed transmission of the Controlled Prescription Program form for the above-named patient. I understand that the Controlled Prescription Program form must be faxed to and received by the pharmacy prior to the pharmacy dispensing methadone. I guarantee that the original Controlled Prescription Program form will be sent to the pharmacy by the next business day.

Brief description of the emergency situation:

Prescriber’s Name: _____

Prescriber ID: _____

Prescriber’s Signature: _____

Signature Date: _____

Affix Controlled Prescription Program form here

Appendix 4

Pharmacist – Prescriber Communication

Date: _____ Patient Name: _____
 To (Prescriber): _____ Patient PHN: _____
 Fax: _____ Prescription Form Folio Number: _____
 From (Pharmacy): _____ Pharmacy Fax: _____
 Pharmacist: _____ Pharmacy Telephone: _____

For Prescriber’s Information and Patient Records

- This patient missed their methadone dose _____ (dates).
- This patient did not take their full daily dose _____ (date) and consumed only _____ mg of the _____ mg prescribed dose.

For Prescriber’s Signature and Return of Form to Pharmacy

- We require clarity regarding the ‘prescribing date’ and/or ‘start day’ for the attached Controlled Prescription Program form. Please indicate the actual ‘prescribing date’ (actual date the prescription was written) and dispensing ‘start date’ or range.

Prescribing Date: _____
 Dispensing Start Date or Range: _____

- We require clarification and/or a change to the ‘Directions for Use’ section of the attached Controlled Prescription Program form.

Description of authorized changes:

Prescriber’s Name: _____
 Prescriber ID: _____
 Prescriber’s Signature: _____
 Signature Date: _____

Affix Controlled Prescription Program form here

Appendix 5

Drug Interactions – General Information

Methadone is extensively metabolized by cytochrome CYP3A4 in liver microsomes. Most drug interactions with methadone are associated with drugs that either induce or inhibit these enzymes.

The sequence of administration of the drugs is the key to evaluating the significance of the interaction. When a patient is stabilized on a drug that affects liver metabolism and methadone is introduced, the interaction may not be observed unless the first drug is discontinued. It is only if a patient is stabilized on methadone and an interacting drug is initiated or discontinued that an interaction may occur.

Drugs that may lower plasma levels (ie; increase the metabolism) of methadone include rifampin, barbiturates, phenytoin and carbamazepine. Drugs that may increase plasma levels (ie; decrease the metabolism) of methadone include ciprofloxacin and fluvoxamine.

Medications that might precipitate a withdrawal syndrome for patients on methadone must be avoided. These are mainly opioid antagonists such as pentazocine, butorphanol, nalbuphine, and naltrexone.

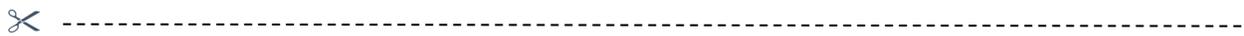
Pharmacists should not rely on PharmaNet to warn of a drug interactions for methadone. The use of PharmaNet is not intended as a substitute for professional judgment. Information on PharmaNet is not exhaustive and cannot be relied upon as complete. The absence of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective in any given patient. Health care professionals should confirm information obtained from PharmaNet, and ensure no additional relevant information exists, before making patient care decisions.

Appendix 7

Methadone Part-Fill Accountability Log

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		



Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Information (if applicable)		Pharmacist's Initials	Patient's signature
		Witnessed	Take Home	Total	Address	Time		