

PREVENTIVE CARE

MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

INITIATION OF THERAPY

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per [ORS 689.645](#), a Pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.
 - Per [ORS 689.698](#), a Pharmacist may prescribe, dispense and administer to a patient medication for the treatment of opioid use disorder in accordance with a statewide drug therapy management protocol, developed in consultation with a physician with a background in addiction medicine, by the Public Health and Pharmacy Formulary Advisory Committee convened under [ORS 689.649](#) and adopted by State Board of Pharmacy rule pursuant to ORS 689.645.
- Following all elements outlined in [OAR 855-115-0330](#), a Pharmacist licensed and located in Oregon may prescribe an MOUD drug regimen.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Initiation of Therapy Patient Intake Form (pg. 2-4)
- Utilize the standardized Initiation of Therapy Assessment and Treatment Care Pathway (pg. 5-8)

PHARMACIST TRAINING AND REGISTRATION REQUIREMENTS

- **Prior to using this protocol, the Pharmacist must:**
 - Complete a total of eight hours of ACPE-accredited (Accreditation Council for Pharmacy Education) training on Opioid Use Disorder (OUD) to include the prescribing of MOUDs, before newly applying for a registration from the DEA to prescribe Schedule III controlled MOUDs for the treatment of OUD.
 - Hold a current Drug Enforcement Agency (DEA) registration for Schedule III Controlled Substances.

RESOURCES

- Standardized Initiation of Therapy Prescription Template *optional* (pg. 9)
- Standardized Initiation of Therapy Provider Communication Template *optional* (pg. 10)
- American Society of Addiction Medicine (ASAM) National Treatment Guidelines for Treatment of OUD https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- Substance Abuse and Mental Health Services Association (SAMHSA) Tip 63: Medications for Opioid Use Disorder- Full Document <https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf>
- American Society of Health-System Pharmacist's Society: Neonatal Opioid Withdrawal Syndrome (NOWS) <https://publications.ashp.org/downloadpdf/display/book/9781585287321/chapter21.pdf>

MOUD Protocol- Patient Intake Form: Initiation of Therapy

(CONFIDENTIAL-Protected Health Information)

Date ____/____/____

Date of Birth ____/____/____ Age ____

Legal Name _____

Name _____

Sex Assigned at Birth (circle) M / F

Gender Identification (circle) M / F / Other ____

Preferred Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other _____

Street Address _____

Phone () _____

Email Address _____

Primary Healthcare Provider Name _____

Phone () _____ Fax () _____

Do you have health insurance? Yes / No

Insurance Provider Name _____

Any allergies to medications? Yes / No

If yes, please list _____

Any allergies to foods (ex. soy, lactose)? Yes / No

If yes, please list _____

To Be Completed by Patient

Section 1- Opioid Use History

Note: We include these questions because they are common signs that opioids may be taking up too much space in someone's life, and it's often hard to realize it's happening. Checking "Yes" just helps us confirm that this specific treatment is the right match for what you're experiencing.

1.	<p>Have you been diagnosed with, or believe you might have, Opioid Use Disorder (OUD)? Some symptoms might include:</p> <ul style="list-style-type: none">• Taking opioids in larger amounts, or over a longer period, than intended• Being unable to cut down use despite trying• Having a strong desire or urge to use opioids ("cravings")• Difficulty keeping up with major responsibilities (at home, work, school, etc.) because of opioid use• Continuing to use opioids even when it causes problems in your personal life or relationships (with friends, family, people at work, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<p>Have you taken any opioids within the last 7 days? (for example, fentanyl, OxyContin®, Percocet®, oxycodone, hydrocodone, heroin, etc.) If yes, what were they? _____ _____ Approximately when did you take them? _____ _____ How much did you take? _____ _____</p> <p>Note: Being honest about recent use is the best way to keep you safe. This information helps us time your first dose to avoid an intense sickness that can happen if the medicine is started too soon.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>Have you ever had an overdose that involved opioids?</p> <p>Note: We ask this because knowing your history will help us provide the right education and tools to make sure you're protected (like naloxone nasal spray to help reverse an opioid overdose).</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

MOUD Protocol- Patient Intake Form: Initiation of Therapy

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Section 2- Medical History

Liver Function		
4.	Have you ever been told you have liver failure, cirrhosis, or have you experienced "yellowing" of the eyes or skin? Note: We ask about your liver because this medication is processed there. We want to make sure your body can handle the medicine safely.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Conditions and Pain		
5.	Are you currently being prescribed opioid medication for a chronic pain condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Symptoms		
6.	Are you feeling confused or dizzy, or having fever or chills due to an illness that you think is unrelated to withdrawal?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 3- Medication History

7.	Are you currently taking any prescription, over-the-counter (OTC), or herbal medications? If yes, please list. _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Note: We ask this because some common medicines or supplements can change how your treatment works. We want to make sure everything you're taking works well together.		

Section 4- Health and Safety Resources

8.	To support your health during treatment, please indicate if you would like information or supplies regarding the following: (if yes, check all that apply) [] Overdose Reversal: Would you like a prescription for a medicine that might help reverse an opioid-related overdose (naloxone or nalmefene), or information on where to access it? [] Supply Safety (Test Strips): Would you like information on test strips that check for potentially lethal additives in the drug supply (like fentanyl and xylazine), or information on where to access them? [] Infection Prevention: Would you like information on the benefits of using sterile supplies and a safe disposal device, or information on where to access them (to prevent heart and skin infections)? [] Safe Practices: Would you like to discuss "Never Use Alone" resources or rescue breathing techniques?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Would you like information regarding any of the following services? (if yes, check all that apply) [] Residential treatment (inpatient/rehab) [] Outpatient counseling (drug and alcohol counseling, cognitive behavioral therapy, family or couples therapy, etc.) [] Peer support groups (narcotics anonymous, SMART recovery, peer coaching, etc.) [] Case management (help with housing, food, work, etc.) [] Medication management (tapering programs, medication therapy management (MTM) services, psychiatric medication management, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

MOUD Protocol- Patient Intake Form: Initiation of Therapy

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Section 5- Patient Attestation

Patient Attestation: I certify that the information I have provided in this form is true and complete to the best of my knowledge. I understand that being honest about my medical history and drug use is essential for my own safety during treatment.

Patient Signature: _____

Date: _____

To Be Completed by a Pharmacist

Section 6 – Pharmacist Verification of MOUD Therapy

Pull and review patient’s Prescription Drug Monitoring Program (PDMP) report. Document last prescription MOUD.

Medication Name/Form: _____

Dose: _____

SIG: _____

Provider: _____

Date of Last Fill: _____

Last Sold Date: _____

MOUD prescription history not found

MOUD Protocol- Assessment and Treatment Care Pathway: Initiation of Therapy

(CONFIDENTIAL-Protected Health Information)

Patient Demographic Information: D.O.B. Is patient 18 years of age or older?	
<input type="checkbox"/> Yes. Continue	<input type="checkbox"/> No. DO NOT PRESCRIBE. Refer to another provider.
Patient Demographic Information: Medication Allergies Does patient have medication allergy to buprenorphine/naloxone tablets, or any of its components?	
<input type="checkbox"/> Yes. DO NOT PRESCRIBE. Refer to another provider.	<input type="checkbox"/> No. Continue
Opioid Use History (Question 1 on Patient Intake Form) Does patient indicate they have, or believe they might have, OUD?	
<input type="checkbox"/> Yes. Continue	<input type="checkbox"/> No. Discuss with patient. If still No, DO NOT PRESCRIBE.
Liver Safety Review (Question 4 on Patient Intake Form) Does patient have history of liver failure, cirrhosis, or jaundice?	
<input type="checkbox"/> YES. DO NOT PRESCRIBE. Refer to another provider due to potential contraindication.	<input type="checkbox"/> No. Continue
Treatment of Chronic Pain (Question 5 on Patient Intake Form) Is patient currently being prescribed opioids by another provider for the treatment of chronic pain?	
<input type="checkbox"/> Yes. Continue. Notify that prescriber if prescription issued.	<input type="checkbox"/> No. Continue
Acute Illness (Question 6 on Patient Intake Form) Did patient state they are confused or dizzy, or have fever or chills due to an illness they think is unrelated to withdrawal?	
<input type="checkbox"/> Yes. Continue, and refer to ED.	<input type="checkbox"/> No. Continue

MOUD Protocol- Assessment and Treatment Care Pathway: Initiation of Therapy

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Health and Safety Resources (Questions 8 - 9 on Patient Intake Form)

Did patient select any of the items below?

Yes No

If yes, check all that apply.

Health and Safety Resources

✓ all that apply	Topic	Tool
[]	Overdose Reversal	Short-acting Opioid Antagonist (Rx)
[]	Supply Safety (Test Strips)	fentanyl / xylazine test strips (information only)
[]	Infection Prevention	Sterile syringes (information only)
[]	Safe Practices:	Alcohol pads / wound kits (information only)

Would you like information regarding any of the following services? (if yes, check all that apply)

- Residential treatment (inpatient/rehab)
- Outpatient counseling (drug and alcohol counseling, cognitive behavioral therapy, family or couples therapy, etc.)
- Peer support groups (narcotics anonymous, SMART recovery, peer coaching, etc.)
- Case management (help with housing, food, work, etc.)
- Medication management (tapering programs, medication therapy management (MTM) services, psychiatric medication management, etc.)

Yes. Act as indicated and continue.

No. Continue

Patient Attestation

Did patient sign and date attestation?

Yes. Continue

No. Obtain signature, or DO NOT PRESCRIBE.

PDMP Review

Did Pharmacist review patient's PDMP report?

Yes. Patient is candidate for initiation of therapy. Continue and prescribe at-home induction regimen.

No. DO NOT PRESCRIBE.

MOUD Protocol- Assessment and Treatment Care Pathway: Initiation of Therapy
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At-home Induction Regimen

Prescription 1- Buprenorphine and Naloxone (Suboxone) 8 mg /2 mg tablets

QTY: 28 tablets

SIG: Follow instruction sheet and take 2 to 4 tablets under the tongue on Day 1, then take 1 tablet under the tongue two to three times daily every day after that.

Comment: Start when you are in moderate to severe withdrawal.

Note: Instruction sheet **MUST** be given to patient to aid induction.

***Prescription 2- Naloxone (NARCAN) 4 mg nasal spray**

QTY: 1 box (2 single-dose devices)

SIG: Instill 1 spray into one nostril as needed for suspected opioid overdose; If needed, repeat dose, alternating nostrils, every 2 to 3 minutes until the patient responds or until emergency medical assistance becomes available.

***Note:** not required if patient refuses.

RPH Name (print): _____

RPH Signature: _____

Date: _____

STARTING BUPRENORPHINE

DAY 1

Wait until you are in moderate to severe withdrawal to start

Wait 12 hours after your last prescription opioid dose
 Wait 12-24 hours after your last fentanyl use
 Wait 48-72 hours after your last methadone dose

WITHDRAWAL SYMPTOMS

MAKE SURE YOU ARE EXPERIENCING AT LEAST 3 OF THESE SYMPTOMS

Goosebumps	Sweats
Runny nose	Muscle cramps
Big pupils (the black part of your eye)	Anxiety
Stomach cramps	Chills
Diarrhea	Body Aches
Watery eyes	Nausea, vomiting

Take TWO tablets under your tongue

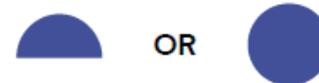


16 mg

Wait 30-60 minutes

Take 1/2-1 tablet every 2 hours as needed for withdrawal symptoms or cravings.

Do not take more than 4 whole tablets in one day



4 mg

8 mg

Day 1 tablet tracker

FILL IN THE TABLETS WITH THE TIME YOU TOOK THEM



DAY 2

Take 1 tablet under your tongue 3 times daily

OR

If you only took 2 tablets on day 1 or you felt too sleepy from buprenorphine then only take 1 tablet twice daily

Morning Afternoon Night

8 mg

8 mg

8 mg



HOW TO TAKE BUPRENORPHINE

- Put the buprenorphine tablet under your tongue
- It will take 5- 15 minutes for the tablet to dissolve
- Do NOT swallow it! It won't work if swallowed
- Do not overlap tablets. You can put one tablet on each side of your tongue

Carry naloxone!



MOUD Prescription Template- Initiation of Therapy

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

Rx

Drug: Buprenorphine and Naloxone 8 mg/2 mg Tablets

- Directions: Follow instruction sheet and take 2 to 4 tablets under the tongue on Day 1, then take 1 tablet under the tongue two to three times daily every day after that.
- Quantity: 28 tablets
- Refills: None

Written Date: _____

Prescriber Name: _____ Prescriber Signature: _____

Prescriber NPI: _____ Prescriber DEA#: _____

Prescriber Address: _____

Prescriber Phone: _____

Provider Notification - Medications for Opioid Use Disorder (MOUD)

Optional-May be used by pharmacy if desired

Pharmacy Name: _____ Pharmacist Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Dear Provider _____ (name), (____) _____ - _____ (FAX)

Your patient _____ (name) ____/____/____ (DOB) was:

Prescribed and dispensed a Medication for Opioid Use Disorder (MOUD) at our Pharmacy noted above on ____ / ____ / _____. The prescription issued and dispensed consisted of:

- Drug: _____
 - Directions: _____
 - Quantity: _____
 - Refills: _____

Prescribed and administered a Medication for Opioid Use Disorder (MOUD) at our Pharmacy noted above on ____ / ____ / _____. The prescription issued and administered consisted of:

- Drug: _____
 - Directions: _____
 - Quantity: _____
 - Refills: _____

NOT prescribed, dispensed or administered a Medication for Opioid Use Disorder (MOUD) at our Pharmacy noted above, because:

Referred to: Primary care provider (PCP) Emergency department (ED) Urgent care
for the following reasons:

RPH Signature: _____ RPH Name (Print:) _____ Date: _____

The prescription was issued pursuant to the Board of Pharmacy [protocol](#) authorized under [OAR 855-115-0330](#).

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