[Patient's contact information]

PHARMACEUTICAL PRESCRIPTION FOR BUPRENORPHINE-NALOXONE (SUBOXONE®) MICRODOSING INDUCTION

Hospital ☐ **Recovery Housing** ☐ **Rehabilitation** ☐ **Frontline** ☐

Allergy/Allergies: _____ No known allergies: ☐ Adverse reactions to medications: _____

PRESCRIPTION FOR BUPRENORPHINE-NALOXONE (SUBOXONE®) MICRODOSING INDUCTION

The principle of microdosing involves gradually inducing microdoses of buprenorphine-naloxone in order to minimize symptoms of withdrawal from the other opioid, which is taken at the same time and discontinued once the therapeutic dose of buprenorphine-naloxone has been reached. See the indication.

***** By convention, the number of milligrams indicated in the dosages corresponds to mg of buprenorphine. *****

INDICATION

QHR notice: **Substitution treatment for opioid use disorder (opioid agonist therapy)**

Period: _____ / _____ / _____ TO _____ /_____ /_____
DD MM YYYY DD MM YYYY

Microdosing Protocol		
Day	Buprenorphine-naloxone dosage	Dosage of the other opioid: _____
1	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
2	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
3	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
4	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
5	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
6	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
7	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
8	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
9	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
10	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
11	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
12	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
13	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation
14	_____mg ☐ QD ☐ BID ☐ Other:_____	☐ Maintenance ☐ Discontinuation

- Number of doses taken in front of the pharmacist (specify number of doses observed per day or week): _____
- The patient can never take more than _____ doses at home between the dates on which he or she must take the medication in front of the pharmacist.

☐ Serve the microdosing protocol in a dispill.

Total quantity of buprenorphine-naloxone for the duration of the prescription: _____ mg

Discontinue all other prescribed opioids (including previous OAT) on day _____ , if more than one opioid, follow these guidelines:

_____

Adjustment to the buprenorphine-naloxone dose at the end of the protocol:

- Starting on day _____ (end of the protocol), continue with _____ mg of buprenorphine-naloxone QD.
- Allow _____ buprenorphine-naloxone tablets/films of _____ mg _____ PRN, to be used as needed but not exceeding a total dose of 32 mg per day.
- Do not dispense if the patient is visibly under the influence of alcohol or intoxicated by medication or drugs.
- Protocol for a missed dose:

Missed doses	**Recommended action(s)**
Less than 48 hours without a dose	Take the missed dose as soon as possible. Restart the induction schedule from the missed dose.
More than 48 hours without a dose	Reassess the individual. If necessary, contact the prescriber.

Check the following as needed:

☐ Please give the naloxone kit and explain how to use it.

☐ Give the following withdrawal kit:

Symptom	**Drug**	**Quantity**
Nausea	Dimenhydriante : _____ mg	_____ tab
Diarrhea	Loperamide : _____ mg	_____ tab
Anxiety, irritability, perspiration	Clonidine : _____ mg	_____ tab
Insomnia	Diphenhydramine : _____ mg	_____ tab
	Trazodone : _____ mg	_____ tab
	Quetiapine : _____ mg	_____ tab
Pain	Ibuprofen : _____ mg	_____ tab
	Acetaminophen : _____ mg	_____ tab

OTHER MEDICATIONS

Daily dosage of the other opioid: _____ _____ **mg** QD (total quantity for the duration of the prescription: _____ mg) given in addition to buprenorphine-naloxone. Discontinue as per the above microdosing protocol.

Period: _____ / _____ / _____ TO _____ /_____ /_____
DD MM YYYY DD MM YYYY

- Number of doses taken in front of the pharmacist (specify number of doses observed per day or week): _____
- The patient can never take more than _____ doses at home between the dates on which he or she must take the medication in front of the pharmacist.

Be sure to list all other opioids prescribed concurrently here.

CONFIDENTIAL TRANSMISSION BY FAX

Pharmacy: _____

Fax number: _____ Date/Time: _____

[Identification of the prescriber's location of practice]

Prescriber's name (block letters): _____ **Permit n°:** _____

Prescriber's signature: _____ **Date and time:** _____

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