[Patient contact information]

**PHARMACEUTICAL PRESCRIPTION**
**EXTENDED-RELEASE BUPRENORPHINE (SUBLOCADE®)**

**Hospital** ☐ **Recovery housing** ☐ **Rehabilitation** ☐ **Frontline** ☐

Allergie(s): _____ None known: ☐ Adverse reactions to medications: _____

## EXTENDED-RELEASE BUPRENORPHINE (SUBLOCADE®)

**INDICATION**
QHR notice: **Substitution treatment for opioid use disorder (opioid agonist therapy )**
Prescription approved by RAMQ for the period FROM _____ /_____ /_____ TO _____ /_____ /_____

**Step 1 (loading doses): Extended-release buprenorphine (Sublocade®)** _____ mg S/C au niveau de l'abdomen q28 jours x 2:

- Total quantity prescribed: _____ injection(s)
- Serve 1 dose every _____ days

**Step 2 (maintenance dose): Extended-release buprenorphine (Sublocade®)** _____ mg S/C in the abdomen q28 days thereafter:

- Total quantity prescribed: _____ injection(s)
- Serve 1 dose every _____ days

- Expected date of injection (it is recommended to record this date in the QHR for each injection): _____
- If necessary, check the appropriate box:
  - ☐ Deliver to: _____
  - ☐ Administered by a nurse in a pharmacy (if available)
  - ☐ Provide the naloxone kit and please provide instructions on how to use it.
- **The drug must be administered within 26 to 42 days of the last injection. If it cannot be administered within this therapeutic window, the pharmacist should consult the prescriber about readjusting.**
- **Discontinue the previous buprenorphine-naloxone (Suboxone®) prescriptions on the day of the first injection of extended-release buprenorphine (Sublocade®). The first injection is usually administered 24 hours after the last dose of buprenorphine-naloxone (Suboxone®). However, there is no need to delay the injection if the last dose was given on the same day.**

## OTHER MEDICATIONS

## CONFIDENTIAL TRANSMISSION BY FAX

Pharmacy: _____

Fax number: _____ Date/Time: _____

[Identification of the prescriber's location of practice]

**Prescriber's name** (block letters): _____ **Permit no.**: _____

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

**As the prescribing physician of extended-release buprenorphine (Sublocade®), I hereby confirm that:**

- ☐ **I have completed the training required by Health Canada and received the certification developed by Indivior.**
- ☐ **I have sent a copy of my certification to the pharmacy.**

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