[Patient contact information]

PHARMACEUTICAL PRESCRIPTION – SLOW-RELEASE ORAL MORPHINE (KADIAN®)

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

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

SLOW-RELEASE ORAL MORPHINE (KADIAN®)

INDICATION

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

Period: ________ / ______ / ______ TO ________ /________ /________
DD MM YYYY DD MM YYYY

Daily Dosage: ______ mg DIE (Total quantity for the duration of the prescription : __mg)

- Number of daily doses in the presence of the pharmacist _______ days/week.
- The patient can never bring more than _______ doses home between supervised doses taken in the presence of the pharmacist.
- The pharmacist may increase the dose up to _______ mg q.a.d PRN if the patient remains in withdrawal and/or keeps using illicit opioids. Do not increase if highly intoxicated.
- The dose may be increased up to _______ mg total to a maximum permitted of _______ mg q.d.
- **Once two consecutive doses have been missed, the pharmacist should adjust the prescription downward according to the recommended schedule, or refer to the prescriber for a readjustment.**

Number of consecutive missed doses	Example of a prescribed dose: 200mg	Example of a prescribed dose: 800mg
1	200mg	800mg
2	120mg (40% reduction)	480mg (40% reduction)
3	80mg (60% reduction)	320mg (60% reduction)
4	40mg or initial dose (e.g.: 60mg) select the highest (80% reduction)	160mg (80% reduction)
5	Redosing	Redosing

- Do not dispense if the patient is visibly under the influence of alcohol or intoxicated by medication or drugs.
- Check, as needed:
  - ☐ The capsule should be opened during a supervised intake. Sprinkle the pellets into fruit puree, yoghurt, pudding or water and serve immediately. CAUTION: Do not chew, crush or dissolve the granules.
  - ☐ Please provide a naloxone kit and instructions on how to use it.

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:** ______________

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