

RISK MITIGATION

IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

AUTHORS AND REVIEWERS (IN ALPHABETICAL ORDER)

Keith Ahamad, MD; Paxton Bach, MD; Rupi Brar, MD; Nancy Chow, RN; Neasa Coll, MD; Miranda Compton, MSW; Patty Daly, MD; Julius Elefante, MD; Guy Felicella; Ramm Hering, MD; Elizabeth Holliday; Cheyenne Johnson, RN; Perry Kendall, MD; Laura Knebel, MD; Mona Kwong, PharmD; Tamara Mihic, PharmD; Garth Mullins; Daniel Pare, MD; Gerrard Prigmore, MD; Samantha Robinson, RN; Josey Ross, MA; Andy Ryan, MD; Aida Sadr, MD; Christy Sutherland, MD; Meaghan Thumath, RN; David Tu, MD; Sharon Vipler, MD; Jeff West; Evan Wood, MD; Steven Yau, MD

REVIEWED BY:

Ministry of Health
Ministry of Mental Health and Addictions
Office of the Provincial Health Officer
College of Physicians and Surgeons of BC
College of Pharmacists of BC
BC College of Nursing Professionals
First Nations Health Authority

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LAND ACKNOWLEDGEMENT

The BC Centre on Substance Use would like to respectfully acknowledge that the land on which we work is the unceded territory of the Coast Salish Peoples, including the territories of the x^wmeθkwey'em (Musqueam), Skwxwú7mesh (Squamish), and sel'ílweta| (Tsleil-Waututh) Nations.

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BACKGROUND

On March 11, the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. In British Columbia, a public health emergency due to COVID-19 was declared on March 17, 2020. British Columbia is in a unique situation, with the current crisis compounding an existing public health emergency declared in April 2016, due to escalating opioid overdoses and related deaths. At the intersection of these dual public health emergencies are a number of risks, including the risk for overdose and other harms related to an increasingly toxic illicit drug supply, the risk of infection and spread of infection among those with underlying health conditions and who face social marginalization, and risks due to withdrawal for those who must self-isolate or quarantine to prevent the onward spread of COVID-19. Extraordinary measures are needed to support people who use drugs (PWUD) (including alcohol) and prevent ongoing community spread of COVID-19 among a vulnerable, often immune-compromised population.

This protocol is intended to provide clinical guidance to health care providers to support patients to mitigate these competing priorities and compounded risks and enable social distancing and self-isolation measures, where possible, to reduce and prevent the spread of COVID-19. These guidelines are not intended for treatment of substance use disorders but rather to support individuals with substance use disorders to self-isolate or social distance and avoid risk to themselves or others.

DEVELOPMENT

This interim guidance document was developed rapidly to provide clinical guidance in the context of the COVID-19 pandemic. As such, it does not provide a review of the relevant literature, and relies on the clinical judgment of prescribers when utilizing this guidance.

ELIGIBILITY

Target Population

This guidance aims to support individuals who may be at increased risk of overdose, withdrawal, craving, and other harms related to their substance use. As the effects of the pandemic continue, the drug supply may become significantly more adulterated and toxic, based on limited importation and availability, and illicit substances may become significantly more difficult to procure. Individuals seeking illicit substances to prevent withdrawal risk both overdose and exposure to and transmission of COVID-19. Individuals with unstable housing (those who are homeless or living in a shelter, single room occupancy (SRO), or supported housing unit) may face additional challenges physical distancing or self-isolating, in order to reduce community spread of COVID-19.

Eligible clients must meet the criteria below:

- Those at risk of COVID-19 infection, those confirmed COVID-19 positive, or those with a suspected case (e.g., symptomatic and self-isolating)
- Those with a history of ongoing active substance use (opioids, stimulants, alcohol, benzodiazepines, or tobacco)
- Those that are deemed at high risk of withdrawal, overdose, craving, or other harms related to drug use

Youth and people who are pregnant:

- Youth aged <19 may be eligible if there is informed consent by the patient to receive this intervention and additional education is provided. Efforts should be made to offer alternative options (e.g., opioid agonist treatment)
- For youth and pregnant individuals, in collaboration with the patient, referral to health and social services and connection to appropriate resources should be offered

Screening and Assessment

Assessment for eligibility should include the following:

- Active substance use assessment (i.e., type of substance, quantity used, frequency of use)
 - Note: Not all patients who qualify for these medications will use substances daily. For example, people who use stimulants often have a binge pattern of use rather than daily use and would still benefit from support in order to social distance and avoid the illicit market
- Substance use history
- History of overdose
- Comorbid mental and physical conditions
- Prescribed medication(s)
- Current access to a prescriber (i.e., GP, addiction medicine physician, nurse practitioner)

MEASURES IN PLACE TO ENSURE CLINICAL ELIGIBILITY AND TO REDUCE SECONDARY HARMS SUCH AS DRUG DIVERSION

- For any new potential patients unknown to the prescriber, eligibility will include a detailed clinical assessment (see above)
- All patients will be offered referrals to available evidence-based treatment programs based on patient-identified goals (e.g., OAT, recovery-oriented services—where still operating)
- For the safety of all enrolled participants, all pharmaceuticals will be provided daily, when possible. This could be facilitated by the housing provider, pharmacy, or a clinical outreach team. If the patient is on take home doses of OAT, their safe supply prescription can match their OAT prescription, with considerations for storage and safety
- Where medications are not able to be provided daily, individuals will be encouraged to store medications in personal safes or medicine lock boxes in patient-specific lockers on their unit
- Regular follow-up with health care providers to assess clinical and psychosocial stability should be conducted

ENROLMENT AND PRESCRIBING

Patients are encouraged to work with their existing or assigned GP/NP who can use the below protocols and pharmacy delivery as per their usual process. For patients who do not have a GP/NP or for whom the GP/NP declines the service, several resources are available:

- Rapid access addiction clinics (RAACs) may be able to provide telehealth support, both consultation for prescribers and patient assessment.
 - **Victoria:** 250-381-3222
 - **Vancouver:** 604-806-8867
 - **Surrey:** 604-587-3755
- **Rapid Access to Consultative Expertise (RACE) for Addictions** is available M-F 8am-5pm for additional consultation and support: <http://www.raceconnect.ca/>
 - Local calls: 604-696-2131
 - Toll free: 1-877-696-2131
- **OAT Clinics Accepting New Patients:** This list may be consulted for referral, for physicians and nurse practitioners who do not have extensive experience providing addiction medicine whose patients are at risk of withdrawal. <https://www.bccsu.ca/wp-content/uploads/2020/01/OAT-Clinics-Accepting-New-Patients.pdf>
- **VCH:** Physician and pharmacist requests, referrals, and questions should be directed to the Overdose Outreach Team (OOT). The OOT phone line and specialist phone consultation is available 7 days per week, 8:00am to 8:00pm at 604-360-2874.

PANDEMIC PHARMACOTHERAPY PROTOCOLS

In order to reduce the risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply, replacing illicit (i.e., opioids, benzodiazepines, and stimulants) and licit (i.e., alcohol, tobacco products) products with prescribed or regulated substances is recommended. The medications specifically listed in this section are full benefits for coverage under PharmaCare Plan G, Plan C, Plan W, and Plan I (Fair PharmaCare). Registration for PharmaCare Plan G is physician-initiated, though the use of a [short form](#).

Other alternate pharmaceuticals not specifically listed here may be limited coverage benefits or non-benefits under BC PharmaCare. PharmaCare Special Authority is not available for alternate treatments. Please consider the cost to the patient before prescribing alternate treatments. Please confirm PharmaCare coverage status (available via the PharmaCare Formulary Search) before prescribing alternative medication.

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants must be considered. For these individuals, clinical judgement should be used, with priority given to substances associated with risk of severe withdrawal. Patients should be counseled about not sharing smoking devices (cigarettes, joints, vapes, crack pipes, etc). Consider consulting the [RACEline](#) for support when prescribing.

Opioids

In the context of the COVID-19 pandemic, individuals who use opioids may be at greater risk of overdose, withdrawal, craving, and other harms, due to an increasingly limited and toxic illicit drug supply. For patients who use opioids:

- Assess current level of use and presence of withdrawal symptoms and cravings
 - Example questions include:
 - What drugs do you currently use?
 - What kind, how much, and how often?
 - How much money are you spending on drugs?
- Offer opioid agonist therapy (OAT) according to BCCSU guidelines or if they are already on OAT, consider increasing their dose and provide carries and delivery as needed.
<https://www.bccsu.ca/opioid-use-disorder/>
 - The provincial guideline linked above is in the midst of being updated, including titration protocols. If prescribing OAT for this population, more rapid dosing may be appropriate, per clinical discretion. For example,
 - In order to avoid the need for moderate withdrawal, consider using a microdosing protocol to initiate patients onto buprenorphine/naloxone, see [Appendix 1](#). To avoid withdrawal and patient discomfort, consider co-prescribing hydromorphone, slow-release oral morphine (Kadian), or sustained-release oral morphine (M-Eslon) during microinduction

¹ This document was developed rapidly to provide guidance in the context of COVID-19 pandemic, additional resources are available upon request from the BCCSU.

- Some prescribers are starting patients at 40mg methadone per day for both new starts and missed doses, based on clinical judgment
 - Common practice in Vancouver clinics differs from the slow-release oral morphine (SROM) titration guidance provided in the guideline. For example, patients may be started at 200mg and go up by 100mg, based on clinical judgment. Patients with known high tolerance and recent high-dose SROM (e.g., a dose of 1400mg per day, with the last dose 6 days ago) may start at 300mg and go up by 200mg per day, based on clinical judgment
 - Specific guidance for individuals on injectable opioid agonist treatment (iOAT) is forthcoming and will be available on the [BCCSU website](#)
- If patient is using street opioids in addition to their OAT or declines OAT, prescribe according to current use and use patient preference and clinical judgment to select appropriate medications and dosage. The provincial OUD guideline should be used for OAT dosing; for patients needing access to a safe supply of opioids to prevent withdrawal from illicit opioid use, the following guidance should be used.
- Dose and medication should be decided on collaboratively with each individual, in a shared decision-making process. It will depend on if they are being co-prescribed OAT, how much money they spend each day on illicit drugs, and patterns of substance use (i.e., daily or binge). The dose can be adjusted over time, with a goal of the person being comfortable and not needing to access the illicit drug market.
 - Prescribe oral hydromorphone 8mg tablets (1-3 tabs q1h as needed up to 14 tablets), provided daily

AND/OR

Prescribe M-Eslon 80-240mg PO BID provided daily (avoid sprinkling doses)

 - Note: Doses should be started at the lower end of the range unless there is a known tolerance and up-titrated based on patient comfort, withdrawal symptoms, and cravings
 - It is helpful to prescribe a long-acting opioid in conjunction with a short-acting opioid for those not on OAT
 - Witnessed ingestion is not required
 - Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff, if safe)
 - In circumstances in which capacity for daily delivery is limited, consider prescribing a limited quantity of carries (i.e., up to 7 days), where clinically appropriate. Blister pack for safety.
 - Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday
- Example clinical scenarios are provided in [Appendix 4](#) to help guide prescribing

² Using a prime number will enable pharmacy tracking of prescriptions in PharmaNet.

Stimulants

The generally good safety profile of prescribed stimulants^{3,4} suggests that replacement therapy with psychostimulants in order to support a reduced risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply is a reasonable clinical decision in these extraordinary circumstances. For patients with active stimulant use disorder:

- Assess current level of use and presence of withdrawal symptoms and cravings
 - Example questions include:
 - What drugs do you currently use?
 - What kind, how much, and how often?
 - How much money are you spending on drugs?
- If not previously diagnosed, assess using [DSM-5 criteria](#)

For patients with active stimulant use disorder:

- Prescribe Dexedrine:
 - Dexedrine SR (dextroamphetamine) 10-20mg PO BID provided daily with a maximum dose of 40mg BID per day⁵

AND/OR

 - Dexedrine 10-20mg IR PO BID-TID with a maximum dose of 80mg Dexedrine per day

OR

- Prescribe methylphenidate:
 - Methylphenidate SR 20-40mg PO OD with maximum dose of 100mg/24hrs

AND/OR

 - Methylphenidate IR 10-20mg PO BID daily to maximum dose of 100mg methylphenidate per day
- Medication selection should take into account patient preference and current use, and may include only slow-release, only immediate-release, or a combination of the two
- Patients with concurrent psychotic or bipolar disorder should be warned of the potential worsening of symptoms with prescribed stimulant medications and advised to stop or reduce dose and/or present for medical help early should this occur
- Patients should be educated on potential side effects (e.g., heart palpitations, sleeplessness, anxiety, psychotic or manic symptoms) and advised that medication effects may be different than usually experienced with illicit stimulants
- Do not prescribe stimulants for a person with unstable angina or uncontrolled hypertension. Prescribe with caution in those with a cardiac history
- Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff)
- Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday²
- Example clinical scenarios are provided in [Appendix 4](#) to help guide prescribing

³ Bhatt M, Zielinski L, Baker-Beal L, et al. Efficacy and safety of psychostimulants for amphetamine and methamphetamine use disorders: A systematic review and meta-analysis. *Syst Rev.* 2016; 5(1):189. 10.1186/s13643-016-0370-x

⁴ Castells X, Cunill R, Pérez-Mañá C, Vidal X, Capellà D. Psychostimulant drugs for cocaine dependence. *Cochrane Database of Systematic Reviews.* 2016; (9). 10.1002/14651858.CD007380.pub4

⁵ In some clinical practices, doses of 60mg BID are being used; however, there is limited data to support this practice.

Illicit Benzodiazepines

Anecdotally, most individuals using illicit benzodiazepines in BC are using bars of adulterated or counterfeit Xanax (alprazolam) that are actually combinations of unknown substances in unknown dosages. For this reason, it is not possible to estimate tolerance based on patient report. In order to reduce the risk of overdose from the newly prescribed benzodiazepine medication (on its own, or in combination with ongoing concurrent alcohol or illicit drug use), it is therefore important to start with a relatively low dose and titrate up as needed.

For patients at risk of benzodiazepine withdrawal, enquire which benzodiazepine the patient is using and aim to prescribe according to current use. A taper protocol should generally be offered in all cases,⁶ given the known risks of long-term benzodiazepine use, however, to support social distancing and self-isolation, a temporary maintenance protocol may be offered.

- Assess current use and presence of withdrawal symptoms and cravings
 - Example questions include:
 - What drugs do you currently use?
 - What kind, how much, and how often?
 - How much money are you spending on drugs?
- If initiating a taper, clonazepam or diazepam are preferred, as they are long-acting
- If temporary maintenance is being prescribed, generally consider switching to a long-acting benzodiazepine and reduce dose by 50% to start
 - Example maintenance dosing:
 - If the patient describes buying diazepam 10mg x 3/day then consider starting at 5mg TID and increasing the dose as needed
 - If the patient describes using 1-4 “bars” of Xanax, start with clonazepam 0.5mg-1mg BID
- Starting at a lower dose than what your patient regularly purchases and titrating up is important due to varying potencies of illicit benzodiazepines. Be cautious when prescribing benzodiazepines for patients who use opioids or are on OAT as they increase overdose risk
- Review the signs and symptoms of benzodiazepine toxicity (CNS depression ranging from mild drowsiness to a stuporous state and respiratory depression) with the patient
- Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff, if safe)
- Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday⁷
- Due to the diverse range of benzodiazepines, confirming PharmaCare benefit status before prescribing a drug other than diazepam is recommended to avoid unintended out of pocket costs to the patient
- When prescribing benzodiazepines, ensure telemedicine or in-person follow-up, where possible. If concerns of complicated withdrawal, consider outreach team doing regular in-person follow-up (where available)
- Example clinical scenarios are provided in [Appendix 4](#) to help guide prescribing

⁶ Consider consulting the [RACeline](#) for guidance on planning a benzodiazepine taper.

⁷ Using a prime number will enable pharmacy tracking of prescriptions in PharmaNet.

Tobacco and Alcohol

For individuals with **tobacco use disorder** who are not ready to stop consumption (e.g., smoking, vaping):

- Provide nicotine replacement therapy (i.e., patch, gum, lozenge, inhaler)
- For more information on accessing NRT, visit:
<https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program>
- For prescription-based pharmacotherapies for tobacco cessation (i.e., varenicline, bupropion), consider writing longer prescriptions, to reduce the number of clinic visits required and monthly dispense, where clinically appropriate

For patients with **alcohol use disorder**:

- Assess risk of complicated withdrawal using the [Predictive Alcohol Withdrawal Severity Scale \(PAWSS\)](#) and offer pharmacotherapies to manage alcohol withdrawal, where indicated:
 - If low risk of complicated withdrawal (i.e., PAWSS ≤ 3) consider providing withdrawal management medications including gabapentin and/or clonidine or and/or carbamazepine. See [BCCSU Alcohol Guidelines](#)
 - Guidance for health care providers on treating individuals at high risk of complicated alcohol withdrawal is forthcoming and will be available on the [BCCSU website](#)
- Offer relapse prevention pharmacotherapies and other treatments for alcohol use disorder
<https://www.bccsu.ca/alcohol-use-disorder/>

For patients who use alcohol or tobacco chronically and whose cessation may put them at risk for withdrawal, prescribers are encouraged to consider unique solutions, where possible (e.g., managed alcohol or tobacco/nicotine). Prescribers should contact local programs, where they exist, for more information.

Overdose Prevention and Naloxone

Despite being in isolation or practicing physical distancing, patients are encouraged to not use alone. If using with others, suggest maintaining at least 2 metres separation. Individuals are encouraged to use harm reduction best practices to prevent overdose, and be provided with take-home naloxone. Provide education on how patients can avoid using alone while remaining in isolation. Individuals may request a neighbour, loved one, or staff member (e.g., supportive housing) check-in by knocking on the door, may utilize a phone, video or instant messaging buddy system in which a friend or other support person stays on the line and calls 911 if they are unresponsive. Patients should be connected to overdose prevention services where available.

Current guidance from the BCCDC states that, in the case of overdose, 911 should be called, naloxone should be administered, and rescue breaths should be given using a face shield mask found in take-home naloxone kits. More information can be found [here](#). When prescribing medications, consider how patients can access necessary harm reduction supplies (e.g., sterile syringes, vitamin C powder, sterile water).

⁸ Gabapentin was added as a regular benefit under PharmaCare Plan G for the duration of the crisis as of April 1, 2020. Gabapentin is currently a regular benefit under other PharmaCare drug plans, including Plans W, C, and I (Fair PharmaCare).

Delivery Support

The prescriber should identify pharmacies that have delivery services and have the capacity to transport medication to the client's place of residence. Prescriptions will be sent to those pharmacies. Medications will be delivered directly to patients by the pharmacy under their appropriate regulations.

Process of delivery:

- Medications will be delivered directly to the patients. Client identity will be confirmed prior to provision of medication, while maintaining at least 2 metre distance
- Where medications are not able to be provided daily, individuals will be encouraged to store medications in personal safes or medicine lock boxes in patient-specific lockers on their unit.
- If pharmacists do not have capacity, consider other delivery options. See [CPBC website](#) for more information on delivery options
- In circumstances in which capacity is severely limited, consider the capacity of providing weekly delivery rather than daily, which would require prescribing carries (see substance-specific sections above)
- Please refer to the latest updates from the BCCSU regarding transportation of controlled substances, as there have been changes in the context of the COVID-19 public health emergency. Information can be found here: www.bccsu.ca/covid-19

For homeless or precariously housed patients in shared living spaces, patients may be referred for isolation at specified shelters or other locations, in cases of suspected or confirmed COVID-19. Delivery of medication could be arranged for these locations.

Outreach Support

Consider ongoing assessment by phone to ensure the dosing is adequate. It is also important to consider food, fresh air, and entertainment for those in self-isolation. The approach should be flexible in keeping with the pandemic and in the best interest of the client and community.

In regions where overdose outreach teams exist, they may support patients with the following:

- Pharmacy delivery issues
- Prescription changes
- Identification of clinical needs and linkage to care
- Navigating other supportive services during quarantine period
- Harm reduction education and supplies

Rural and Remote Considerations

There are unique barriers to both accessing and providing substance use care in rural and remote areas. Rural and remote communities may have limited health services (e.g., clinics or pharmacies), requiring patients to travel to neighbouring communities to access substance use care. One strategy to mitigate these barriers is the use of telemedicine, which enables family physicians and addiction specialists to consult with patients from a distance; however, telemedicine supports may be limited in some communities, with barriers to access and limited reach.

In the context of these dual public health emergencies, unique barriers may exist in rural and remote settings. These include:

- Limited ability to monitor patients, due to geography and access
- Limited access to outreach resources
- Pharmacy capacity and delivery may be limited
- Limited access to prescribers

Prescribers should consider consulting the [RACeline](#) if requiring an addiction medicine consult.

Appendix 1: Buprenorphine/Naloxone Microinduction Protocol

The BC Pharmacy Association has published several buprenorphine/naloxone microinduction protocols using the Bernese method.⁹ A slower and faster microinduction protocol are provided here, adapted from the [BC Pharmacy Association's](#) guidance.

| Slower microinduction protocol | |
|--------------------------------|---------------|
| Day | Dose |
| 1 | 0.25mg SL |
| 2 | 0.25mg SL BID |
| 3 | 0.5mg SL BID |
| 4 | 1mg SL BID |
| 5 | 2mg SL BID |
| 6 | 4mg SL BID |
| 7 | 12mg SL |
| 8 | 12mg SL |

| Faster microinduction protocol | |
|--------------------------------|--------------------|
| Day | Dose |
| 1 | 0.5mg SL BID |
| 2 | 1mg SL BID |
| 3 | 2mg SL BID |
| 4 | 3mg SL BID |
| 5 | 4mg SL BID |
| 6 | 12mg SL once daily |
| 7 | 16mg SL once daily |

Additional guidance is available from the [BC Pharmacy Association](#). Consider consulting the [RACE line](#) if additional guidance required.

⁹ Hämig R, Kemter A, Strasser J, et al. Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: The bernese method. *Substance Abuse and Rehabilitation*. 2016; 7:99-105. 10.2147/SAR.S109919

Appendix 2: Benzodiazepine Equivalence Table

This benzodiazepine equivalent doses table may help estimate a target dose when converting from illicit to prescribed benzodiazepines. In line with guidance given above, patients should be started at a lower dose than what they regularly purchase and titrated up.

| Benzodiazepine Equivalent Doses ¹⁰ | |
|--|-------------------------------------|
| | Equivalent to 5mg Diazepam (Valium) |
| Alprazolam (Xanax) | 0.5mg |
| Bromazepam (Lectopam) | 3-6mg |
| Chlordiazepoxide (Librium) | 10-25mg |
| Clonazepam (Klonopin, Rivotril) | 0.5-1mg |
| Clorazepate (Tranxene) | 7.5mg |
| Flurazepam (Dalmane) | 15mg |
| Lorazepam (Ativan) | 0.5-1mg |
| Nitrazepam (Mogadon) | 5-10mg |
| Oxazepam (Serax) | 15mg |
| Temazepam (Restoril) | 10-15mg |
| Triazolam (Halcion) | 0.25mg |
| <i>Note: These equivalences are approximate.</i> | |

¹⁰ National Pain Centre. 2017. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: Appendix 6— Benzodiazepine Tapering. McMaster University. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html

Appendix 3: Example Prescriptions

Note: These prescriptions assume that the patient is to not have carries. The instructions would need to be adjusted should there be a need for carries as per usual written requirements.

Hydromorphone:

| B.C. CONTROLLED PRESCRIPTION FORM | | | | | |
|--|---------------|------------------------------------|---|-----------------|--|
| Take to pharmacy of choice. | | | | | |
| PLEASE PRINT | | | | | |
| PERSONAL HEALTH NO. 123456789 | | | PRESCRIBING DATE 01 DAY 04 MONTH 20 YEAR | | |
| PATIENT NAME | FIRST Jill | INITIAL X | LAST Smith | | |
| ADDRESS 123 45th St. | | | | | |
| CITY | Any town | PROV. BC | DATE OF BIRTH 26 DAY 12 MONTH 82 YEAR | | |
| Rx - DRUG NAME AND STRENGTH | | ONLY ONE Rx PER FORM | | VOID if altered | |
| Hydromorphone 8mg | | tablets | | | |
| NUMERIC | QUANTITY | ALPHA | | | |
| 2576mg | | twenty-five hundred seventy-six mg | | | |
| DIRECTIONS FOR USE | | | | | |
| Hydromorphone 8mg, 1 to 3 tabs q1h PO as needed up to 14 x 8mg tablets/day Daily dispensed, not witnessed Rx: April 1 – 23/2020 (23 days) | | | | | |
| NO REFILLS PERMITTED VOID AFTER 5 DAYS UNLESS PRESCRIPTION FOR METHADONE MAINTENANCE | | | PRESCRIBER'S SIGNATURE  | | |
| Dr. Wendy Osler 543 21st St. Any town BC V2K 2B6 | | | COLLEGE I.D. # 12345 67 | | |
| | | | FOLIO 12345678 | | |
| PHARMACY USE ONLY | | | | | |
| RECEIVED BY - PATIENT OR AGENT SIGNATURE | | | SIGNATURE OF DISPENSING PHARMACIST | | |
| PHARMACY COPY - COPYING OR DUPLICATING THIS FORM IN ANY WAY CONSTITUTES AN OFFENSE | | | | | |
| PRESS HARD YOU ARE MAKING 2 COPIES PRINTED IN B.C. | | | | | |

Methylphenidate¹¹:

DR. WENDY OSLER
543 21st St.
Any town BC V2K 2B6
Tel: 250-999-9911
Fax: 250-999-9119

NAME: SMITH, Jill
PHONE: (250) 999-0000
PHN: 01233 456 789
DOB: 12-December-1982
ADDR: 123 45th St Anytown BC V3T 9Z9
DATE: 1 Apr 2020

1) **Methylphenidate Tab 10mg IR**
Take one tablet PO twice daily
Dispense: 46 tablet(s)

Directions - For Pharmacist: Daily dispensed, not witnessed
Rx: April 1 – 23/2020 (23 days)

Signature 
MSP: 00000 CPSID: 07811

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¹¹ This is an example prescription from the Plexia EMR system.

Appendix 4: Example Clinical Scenarios

These clinical scenarios are intended to provide examples of how this interim guidance can be utilized. These examples represent one approach and should not supersede clinical judgment. If prescribing multiple sedating agents (e.g., opioids, benzodiazepines, alcohol), discuss the compounded risk of respiratory depression and overdose, and ensure patient has a take-home naloxone kit and has been trained on how to administer naloxone.

Concurrent Opioid and Benzodiazepine Use

Sandra, a 42-year old trans woman, has a visit through telehealth and reports mild upper respiratory tract infection symptoms. Sandra uses opioids daily and benzodiazepines when she can get them. Your assessment of Sandra shows:

- Stable housing
- Using 250mg fentanyl IV per day (injects 2–3 times per day)
- On average, uses street-obtained Xanax PO 4mg tabs 3 times per day
- Not on OAT x 6 months, previously on methadone but found side effects intolerable
- No history of complicated withdrawal from benzodiazepines (no seizures/DTs, has skipped days without benzodiazepines) but feels she'll need them to be able to stay in her room
- Declined OAT

Plan

Inform Sandra she must stay at home, away from other people, and to seek emergency help if she has trouble breathing.

Opioids:

- Offer a restart on methadone or start on another OAT medication, which she declines today, but will consider
- M-Eslon 150mg PO BID
- Hydromorphone 16–24mg BID–TID (max 9 tabs per day of 8mg)
- Delivered; daily dispense, not witnessed

Benzodiazepines:

- Alprazolam 2mg PO BID
- Daily dispense, not witnessed

When prescribing benzodiazepines, ensure telemedicine or in-person follow-up where possible. Doses may need to be adjusted as starting doses are 50% reported use. If concerns of complicated withdrawal, consider outreach team doing regular in-person follow-up (where available).

Concurrent Opioid and Stimulant Use

Amaya, a 45-year old female comes to see you, concerned that she will go in withdrawal if she needs to self-isolate or quarantine. Amaya has stable housing. Amaya reports no symptoms of upper respiratory tract infection. Amaya uses both opioids and crystal methamphetamine daily. Your assessment of Amaya shows:

- Using 1 point/day IV (100mg) of heroin (injects 3 times/day)
- Using 1 point/day IV (100mg) of crystal methamphetamine IV (injects 2–3 times/day)
- Not on OAT and has never trialled OAT
- Declines OAT today

Plan

Opioids:

- Hydromorphone 16mg PO TID (max 6 tabs per day of 8mg)
- M-Eslon 100mg PO BID (for long-acting coverage)
- Daily dispense, not witnessed

Stimulants:

- Dexedrine 10mg SR PO BID

OR

- Dexedrine 10mg IR BID–TID
- Delivered; daily dispense, not witnessed

Arrange regular in-person follow-up with local outreach team, if available. Follow up with telehealth visits, and encourage her to call in to discuss how she is feeling and if the doses are adequate.

Concurrent Opioid, Crystal Meth, and Tobacco Use

Aroon, a 39-year old male, comes to see you. He reports that he is worried about COVID-19, has had exposure to some friends with colds, and wants to self-isolate. Your assessment of Aroon shows:

- Patient is asymptomatic —no fever, no cough, no malaise
- Has fixed, safe, housing
- Uses 1gram fentanyl IV and smokes crystal methamphetamine daily—uses concurrently 3-4 times/day
- Smokes 10 cigarettes per day
- No alcohol or benzodiazepine use
- Dealer has limited supply that is too expensive for patient to access. He is at risk of withdrawal
- Last on slow-release oral morphine 1 year ago, confirmed on PharmaNet. Has not been on OAT since

Plan

Opioids:

- Methadone 30mg PO once daily
- Hydromorphone 24mg PO TID–QID (max 12 tabs per day of 8mg)
- Delivered; daily dispense, not witnessed

Stimulants:

- Dexedrine 10mg IR PO TID (max 60mg/24hrs)

OR

- Dexedrine 20mg SR BID with 10mg IR q4–6h PRN (max IR 20mg/day)
- Delivered; daily dispense, not witnessed

Nicotine:

- Nicotine patch 21mg daily
- Monthly dispense and delivery

Arrange regular in-person follow-up with local outreach team, if available, as well as telemedicine visits with the prescriber to discuss how he is doing.

High Risk of Severe Alcohol Withdrawal

Simon, a 59-year old male with suspected COVID-19, has been referred to you by an outreach worker concerned about his risk of severe complications from alcohol withdrawal. Your assessment of Simon shows:

- Past medical history of alcohol-induced hepatitis
- Patient has no fixed address
- Currently drinks whatever he can to avoid withdrawal, trying to avoid non-beverage alcohol but uses non-beverage alcohol occasionally
- On average, will drink 8 beers/day (355mL cans)
- Past history of seizures, several years ago
- Smokes crack cocaine when with friends (1-2x per month), does not have any withdrawal when he does not use crack
- Patient does not want withdrawal management
- PAWSS score >4
- Given past history of seizures and PAWSS score, the patient is at risk of severe alcohol withdrawal

Plan

Note: This plan will depend on local resources

Option 1: Where outreach teams have capacity

- Prescribe daily delivery of beer 8 cans/day (verbal order to case management/outreach team)
- OOT finds patient temporary housing in new VCH shelters
- OOT daily delivers the alcohol and calls prescriber with follow-up on patient's clinical status
- Outreach team does regular assessment to ensure no withdrawal and safety

Option 2: Where outreach teams do not have capacity or do not exist

- Contact [local managed alcohol program](#), where applicable¹²
- Contact inpatient detox facility for withdrawal management and relapse prevention planning
- If inpatient detox facility does not have capacity:
 - Discuss risk of abrupt cessation and [safer drinking strategies](#)
 - Create plan for client to receive delivery from local liquor store
 - Calculate number of drinks required to avoid withdrawal and encourage regular consumption (e.g., every 1-2 hours) to avoid withdrawal
- Provide regular follow up using telehealth or video conference software

¹² Many existing MAPs programs are at capacity currently. The [BCCSU website](#) will provide updates as new managed alcohol services are available in each regional health authority.

Appendix 5: Resources

Harm Reduction Guidance for COVID-19:

<http://www.bccdc.ca/health-info/diseases-conditions/covid-19/priority-populations/people-who-use-substances>

Prescribing resources:

BCCSU Guidelines:

- [Opioid Use Disorder](#)
 - [Guideline for the Clinical Management of Opioid Use Disorder](#)
 - [Opioid Use Disorder—Diagnosis and Management in Primary Care \(BCCSU/GPAC\)](#)
 - [Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder](#)
 - [Treatment of Opioid Use Disorder During Pregnancy](#)
 - [Treatment of Opioid Use Disorder for Youth](#)
- [Alcohol Use Disorder](#)

If patients are self-isolating, they may be candidates for home induction of buprenorphine/naloxone. GPAC and the BCCSU co-developed a patient handout for home induction, available [here](#). [Fraser Health](#) and [Island Health](#) have also developed patient handouts for home inductions.

Expert Support:

Rapid Access to Consultative Expertise (RACE) for Addictions is available M-F 8am-5pm for additional consultation and support <http://www.raceconnect.ca/>

Local calls: 604-696-2131

Toll free: 1-877-696-2131

Some rapid access addiction clinics (RAACs) are equipped to provide telehealth support, both consultation for prescribers and patient assessment.

Victoria: 250-381-3222

Vancouver: 604-806-8867

Surrey: 604-587-3755

OAT Clinics Accepting New Patients: This list may be consulted for referral, for physicians and nurse practitioners who do not have extensive experience providing addiction medicine whose patients are at risk of withdrawal.

<https://www.bccsu.ca/wp-content/uploads/2020/01/OAT-Clinics-Accepting-New-Patients.pdf>

BC Centre on Substance Use COVID-19: Information for opioid agonist treatment prescribers and pharmacists, as well as information for people who use drugs is available at: www.bccsu.ca/covid-19 and <https://www.bccsu.ca/opioid-use-disorder/>

Patient resources:

Patients may benefit from the following resources:

- Ministry of Health [self-assessment tool](#) for COVID-19 symptoms.
- 811 can provide medical advice, information on COVID-19, and instructions on what to do if patients are experiencing symptoms.
- For non-medical information about COVID-19, 1-888-COVID19 (1-888-268-4319; call) or 604-630-0300 (text) from 7:00 am to 8:30 pm every day provides information about physical distancing and what kinds of support, resources, and assistance are available from the provincial and federal governments.
- The BC Centre for Disease Control has advice specifically for harm reduction and overdose prevention – find it [here](#).
- The BCCSU has patient-facing materials available at www.bccsu.ca/covid-19.

