Appendix 14

EXAMPLE: Medication PARQs (Procedures, Alternatives, Risks and Questions)**:**

Buprenorphine-naloxone Induction PARQ – Pt meets DSM-5 criteria for severe opioid use disorder. Patient appears to be a good candidate for outpatient treatment with pharmacotherapy with buprenorphine-naloxone. They appear highly motivated to quit and requests buprenorphine treatment. We discussed alternative treatments, including methadone maintenance and naltrexone, but they would prefer to initiate buprenorphine-naloxone at this time. I counseled them regarding the specific risks and benefits of buprenorphine-naloxone use. We briefly reviewed again what is expected of patients in buprenorphine treatment programs including urine drug testing, frequent medical visits, and outpatient counseling.

We reviewed a regimen for buprenorphine-naloxone induction. We reviewed the side effects of buprenorphine-naloxone including precipitated opioid withdrawal if taken too soon, physical dependence, sedation, overdose risk, constipation, urinary retention, and neonatal abstinence syndrome (if applicable). I informed the patient that benzodiazepines and alcohol are contraindicated with this buprenorphine-naloxone. I reviewed the mechanism of action of buprenorphine, its long half-life (24-36 hours), and how it is administered. I reviewed that it is only active sublingually and it must be fully dissolved before it is active (this can take up to 10-15 minutes). I advised the patient not to inject or snort the medication or it will activate the naloxone component of the medication and block the opioid affects. I reviewed our buprenorphine-naloxone induction schedule.

I answered any questions. The patient expressed understanding and agreement with the above.

Naltrexone ER PARQ – I discussed the possible role of ER naltrexone with patient today. We discussed that ER naltrexone is administered as an intramuscular injection given every 28 days. We discussed the expected benefits and side effects. We discussed that people are at a lower risk of overdose while the naltrexone is effective; however they are at a higher overdose risk when the medication wears off at or beyond 28-30 days. We discussed the most common side effects are nausea and injection site reaction.

We discussed how opioids (including opioid pain medications) do not work while naltrexone is active. Thus, if patient were to have unanticipated acute pain needs, opioid-alternatives would have to be used.

We also discussed risk of precipitated withdrawal if naltrexone is administered with opioids in the body, and discussed the role for a naloxone challenge prior to administration of naltrexone.

Patient asked appropriate questions and was engaged in the conversation about medications.