PHARMACIST ASSESSMENT RECORD – METHADONE MAINTENANCE TREATMENT EXTENSION

Patient Information

Name (Last, First): ______________________ DOB: Click to enter a date.

HSN: __________________ Address: __________

☐ Patient was under care of Dr. ________________ and needs an extension of methadone prescription pursuant to the Health Canada Exemption (insert details of authority to extend). Refer patient if dose change and/or physician's input is required. Urine drug screening is NOT required to extend the prescription.

Patient Assessment and Eligibility

☐ Ensured **no contraindications to methadone**, as per product's monograph

Including, but not limited to, GI obstruction, symptoms of opioid overdose, concomitant MAO inhibitor therapy, pseudomembranous colitis diarrhea, recent head injury, significant respiratory compromise, acute abdominal conditions, unexplained syncope or seizures

☐ Ensured **patient is clinically and socially stable** (e.g., no evidence of misuse of methadone and/or other CNS drugs, no existing or risks of methadone toxicity and/or withdrawal, no suicidal ideation)

☐ Ensured **patient is aware of QT interval prolongation risk** and there are no additional unmanaged risk factors since last fill

Including, but not limited to, serum potassium ≤ 3.5 mmol/L, new QT-prolonging drug(s), heavy alcohol consumption, use of cocaine and other stimulants, conditions leading to electrolyte disturbances. Inquire about presence of any new chest pain or discomfort, dizziness, lightheadedness, palpitations, syncope.

☐ Assessed and **managed drug interactions** (e.g., CNS depressants, QT-prolonging drugs, CYP P450 interactions)

☐ **Assessed adherence** to methadone maintenance treatment

Refer to CPSS SK Opioid Agonist Therapy Program Guidelines for standards re: spoiled, missed and lost doses. 1-2 missed consecutive days at any dose do NOT require a dose change.

☐ **Assessed patient's tolerability** to methadone and **management of side effects** (e.g., constipation, sweating)

Prescription Extended (Unable to Access Supply) – attach copy of prescription from last fill

Rx: Methadone _________ mg PO once daily

Total authorized quantity (numerical and written): ________________________

Witness: Daily unless closed or Mon -- Tue – Wed -- Thur – Fri – Sat – Sun

Carry: Mon -- Tue – Wed -- Thur – Fri – Sat – Sun

Pharmacy/address: __________ Phone Number: __________

Prescribing Pharmacist's Name: __________ Prescribing Pharmacist's License: ___________

Date: Click to enter a date. Prescribing Pharmacist's Signature: