PHARMACIST ASSESSMENT RECORD – SUBOXONE® 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 Suboxone® 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 Suboxone®**, as per product's monograph

Including, but not limited to, significant respiratory compromise, severe hepatic impairment, known or suspected mechanical GI obstruction or surgical abdomen, concomitant MAO inhibitors, patients with convulsive or seizure disorder

☐ Ensured **patient is clinically and socially stable** (e.g., no evidence of ongoing problematic substance use, no signs and symptoms of withdrawal/toxicity, no evidence of acute or unstable psychiatric symptoms, including absence of 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, CYP 3A4 interactions, serotonergic drugs, opioid antagonists)

☐ **Assessed adherence** to Suboxone® maintenance treatment

Refer to CPSS SK Opioid Agonist Therapy Program Guidelines for standards re: spoiled, missed and lost doses.

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

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

Rx: Suboxone® _________ mg SL ___________ (frequency)

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: